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CHAPTER 71.

ACCIDENT AND HEALTH INSURANCE

ARTICLE 1.

GENERAL PROVISIONS

SECTION 38-71-10. Coverages which may be written by licensed accident and health insurers.

All licensed accident and health insurers are entitled to:

- (a) Issue and deliver service benefit contracts to provide for prepayment of any health care service and to make payment directly to the provider of the services, in whole or in part, including, but not limited to, professional services, any institutional care, personal services, and supplies.
- (b) Issue and deliver contracts of indemnity or contracts providing for payment of money directly to the insureds or for them for health care services.

SECTION 38-71-20. Insurers may act as administering agency for government-sponsored health, hospital, and medical service programs.

Insurers licensed to do business in this State have the corporate power to contract to act as agent in the administration of programs of health, hospital, and medical insurance sponsored or financed by an agency of the United States Government or any political subdivision.

SECTION 38-71-30. Whole contract, including application, must appear in policy; oral applications.

Every insurer doing accident or health insurance business in the State shall deliver with each policy of insurance issued by it a copy of the application made by the insured so that the whole contract appears in the application and policy of insurance. If the insurer violates this requirement, no defense is allowed to the policy on account of anything contained in or omitted from the application. If the insurance policy is issued upon an oral application, no defense is allowed to the policy on account of anything contained in or omitted from the oral application.

SECTION 38-71-40. Effect of false statement in application.

The falsity of any statement in the application for any policy covered by this chapter does not bar the right to recovery thereunder unless the false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

SECTION 38-71-46. Diabetes Mellitus coverage in health insurance policies; diabetes education.

(A) On or after January 1, 2000, every health maintenance organization, individual and group health insurance policy, or contract issued or renewed in this State must provide coverage for the equipment, supplies, Food and Drug Administration-approved medication indicated for the treatment of diabetes, and outpatient self-management training and education for the treatment of people with diabetes mellitus, if medically necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina. This subsection does not prohibit a health maintenance organization or an individual or a group health insurance policy from providing coverage for medication according to formulary or using network providers. Coverage must not be denied unless the health care professional demonstrates a persistent pattern of failure to adhere to the minimal

standards of care and unless the health maintenance organization or insurer has first provided written notice to the health care professional that coverage will be denied if the health care professional fails to adhere to the minimal standards of care.

(B) Services and payment for diabetes education programs shall conform to regulations of the Health Care Financing Administration, US Department of Health and Human Services, pursuant to Section 4105 of the Balanced Budget Act of 1997. Diabetes outpatient self-management training and education shall be provided by a registered or licensed health care professional with certification in diabetes by the National Certification Board of Diabetes Educators, or other accredited program approved by the Diabetes Initiative of South Carolina, or by the Diabetes Control Program of the SC Department of Health and Environmental Control in order to meet the needs of rural communities wherein certified health care professionals providing this service are not available.

(C) Nothing contained in this section may be construed to affect in any way the ability of a managed care plan to credential or re-credential a provider.

(D) For purposes of this section: "Health insurance policy" means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

SECTION 38-71-50. Alteration of application.

No alteration of any written application for insurance by erasure, insertion, or otherwise may be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant is a misdemeanor. However, insertions may be made by the insurer, for administrative purposes only, in a manner that clearly indicates that the insertions are not to be ascribed to the applicant.

SECTION 38-71-60. Certain acts do not constitute a waiver by insurer.

The acknowledgment of any insurer of the receipt of notice given under any policy covered by this chapter, the furnishing of forms for filing proofs of loss, the acceptance of proofs of loss, or the investigation of any claim thereunder does not operate as a waiver of any of the rights of the insurer in defense of any claim arising under the policy.

SECTION 38-71-70. Certain policies may conform to laws of other states.

Any foreign insurer authorized to do business in this State may, with the approval of the director or his designee, insert in any policy covered by this chapter so issued or delivered any provision required by the laws of any state or country in which the insurer is licensed, if the provision is not substantially in conflict with any law of this State. A domestic insurer may insert in any policy covered by this chapter issued for delivery in another state or foreign country and governed by the laws thereof any provision required by the laws of the other state or country applicable to the policy.

SECTION 38-71-80. Construction of policy issued in violation of chapter.

A policy issued in violation of this chapter is held valid but must be construed as provided in this chapter, and, when any provision in the policy is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the policyholder, and the beneficiary are governed by the provisions of this chapter.

SECTION 38-71-90. Penalty for violation of chapter.

An insurer or its officer or agent that issues or delivers to any person in this State any policy in wilful violation of any of the provisions of this chapter is subject to the provisions of Section 38-2-10 for each offense.

SECTION 38-71-100. Policies exempt from chapter.

Nothing in this chapter applies to or affects:

- (1) any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary coverage therein;
- (2) any policy or contract of reinsurance;
- (3) any blanket or group policy of insurance, except as specifically required in this chapter; or
- (4) life insurance, endowment, or annuity contracts or contracts supplemental thereto which contain only such provisions relating to accident and health insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident or (b) operate to safeguard the contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

SECTION 38-71-110. Notice of failure of employer to remit deducted premium required before forfeiture.

No insurer doing business in this State and issuing health or accident insurance policies, other than contracts of group insurance of disability, accidental death, or disability and accidental death benefits in connection with policies of life insurance, the premium for which is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the insured and delivered to the insurer or the insured's employer authorizing the deduction of premium installments from the insured's salary or wages, may, during the period for which the policy is issued and while the insured remains employed by the authorized employer, declare forfeited or lapsed the policy until and unless a written or printed notice of the failure of the employer to remit the premium or installment thereof, stating the amount or portion thereof due on the policy and to whom it must be paid, has been duly addressed and mailed to the person who is insured under the policy at least fifteen days before the policy is terminated or lapsed.

SECTION 38-71-120. Repealed by 2006 Act No. 332, Section 31, eff June 1, 2006.

SECTION 38-71-125. Mastectomies; hospitalization requirements; early release provisions.

All individual and group health insurance policies and health maintenance organizations providing coverage for the hospitalization for mastectomies must provide benefits for hospitalization for at least forty-eight hours following a mastectomy. Nothing in this section shall be construed to prohibit an attending physician from releasing the patient prior to the expiration of the time provided herein. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending physician.

SECTION 38-71-130. Breast reconstruction and prosthetic devices; coverage following mastectomy surgery.

All individual and group health insurance policies and health maintenance organizations providing coverage for mastectomy surgery must provide coverage for prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined medically necessary by the patient's attending physician with the

approval of the insurer or HMO. The provisions of this section shall not require supplemental health insurance policies to provide coverage for reconstruction of the non-diseased breast.

SECTION 38-71-135. Minimum postpartum hospitalization and attendant services for mothers and newborns.

All individual and group health insurance and health maintenance organization policies providing coverage for the hospitalization and attendant professional services of a mother and her newborn child or children must provide for the mother and her newborn child or children to remain in the hospital for at least forty-eight hours after a vaginal delivery, not including the day of delivery, and at least ninety-six hours following a Cesarean Section, not including the day of surgery. Nothing in this section shall be construed to prohibit the attending physician, in consultation with the mother, from requesting additional time for hospitalization or from releasing the mother or her newborn child or children prior to the expiration of time provided herein.

SECTION 38-71-140. Coverage of newborn children.

(A) All individual and group health insurance policies providing coverage on an expense-incurred basis and individual and group service or indemnity-type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber, as to the family member's coverage, also must provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(B) The coverage for a newly born child consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(C) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

(D)(1) The provisions of this section apply to a child with respect to whom a decree of adoption by the insured or subscriber has been entered within thirty-one days after the date of his birth and to a child with respect to whom:

(a) Adoption proceedings have been instituted by the insured or subscriber within thirty-one days after the date of his birth and the insured or subscriber has temporary custody pursuant to Section 20-7-1738;

(b) The adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child pursuant to Section 20-7-1760.

(2) Coverage must be provided as long as the insured or subscriber has custody of the child pursuant to decree of the court and the required premiums or fees are furnished to the insurer or nonprofit service or indemnity corporation.

SECTION 38-71-143. Health plans must provide same coverage for children placed for adoption.

(A) If an individual or group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

(B) A group health plan may not restrict coverage under the plan of a dependent child adopted by a participant or beneficiary or placed with a participant or beneficiary for adoption solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage

under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(C) For the purposes of this section:

- (1) “child” means, in connection with an adoption or placement for adoption of the child, an individual who has not attained age eighteen as of the date of the adoption or placement for adoption;
- (2) “placement for adoption” means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child’s placement with a person terminates upon the termination of the legal obligations.

SECTION 38-71-145. Required coverage for mammograms, pap smears, and prostate cancer examinations; limitations.

(A) All individual and group health insurance and health maintenance organization policies in this State shall include coverage in the policy for:

- (1) mammograms;
- (2) annual pap smears;
- (3) prostate cancer examinations, screenings, and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society.

(B) The coverage required to be offered under subsection (A) may not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to that coverage unless these provisions apply generally to other similar benefits provided and paid for under the health insurance policy.

(C) Nothing in this section prohibits a health insurance policy from providing benefits greater than those required to be offered by subsections (A) and (B) or more favorable to the enrollee than those required to be offered by subsections (A) and (B).

(D) This section applies to individual and group health insurance policies issued by a fraternal benefit society, an insurer, a health maintenance organization, or any similar entity, except as exempted by ERISA.

(E) For purposes of this section:

(1) “Mammogram” means a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a physician referral or by a health testing service which utilizes radiological equipment approved by the Department of Health and Environmental Control, which examination may be made with the following minimum frequency:

- (a) once as a base-line mammogram for a female who is at least thirty-five years of age but less than forty years of age;
- (b) once every two years for a female who is at least forty years of age but less than fifty years of age;
- (c) once a year for a female who is at least fifty years of age; or
- (d) in accordance with the most recent published guidelines of the American Cancer Society.

(2) “Pap smear” means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a medical doctor, which examination may be made once a year or more often if recommended by a medical doctor.

(3) “Health insurance policy” means a health benefit plan, contract, or evidence of coverage providing health insurance coverage as defined in Section 38-71-670(6) and Section 38-71-840(14).

SECTION 38-71-147. Freedom of selection and participation in individual or group accident and health or health insurance policy or health maintenance organization plan.

An individual or group accident and health or health insurance policy or a health maintenance organization plan may not:

(1) prohibit or limit a person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of the person's choice who has agreed to participate in the plan according to the terms offered by the insurer; or

(2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services including, but not limited to, prescription drugs that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer.

SECTION 38-71-150. Required provision in policies as to examination and surrender of policy for return of premium.

Every individual or family accident and health or hospitalization policy, certificate, contract, or plan, except trip or travel ticket policies, issued for delivery in this State shall have printed thereon or attached thereto a notice to the insured that ten days are allowed, from the date of the receipt of the policy to examine its provisions and that the insured may for any reason surrender the policy to the insurer. In addition, if the policy was solicited by a direct response insurer, rather than through a licensed insurance agent, the policy, certificate, contract, or plan shall have printed thereon or attached thereto a notice to the insured that thirty days are allowed from the date of the receipt of the policy to examine its provisions and that the insured may for any reason surrender the policy to the insurer. Any premium advanced by the insured, upon appropriate surrender as provided herein, must be immediately returned in full by the insurer to the insured.

SECTION 38-71-160. When policy sold on direct response basis considered to be returned.

For purposes of Section 38-71-150, the insured is considered to have returned a policy sold on a direct response basis as of the date shown on the postmark or the date the insured notifies the insurer or an agent of the insurer, in writing or in person, that the insured does not want the policy, whichever is the earlier.

SECTION 38-71-170. Required provision in policies for conversion privileges for former spouses.

No policy or certificate of accident, health, or accident and health insurance issued or delivered in this State which in addition to covering the insured also provides coverage to the spouse of the insured may contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of an entry of a valid decree of divorce between the parties.

Every policy which contains a provision for termination of coverage of the spouse upon divorce shall contain a provision to the effect that upon the entry of a valid decree of divorce between the insured parties the divorced spouse is entitled to have issued to him or her, without evidence of insurability, upon application made to the insurer within sixty days following the entry of the decree, and upon payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is most nearly similar to, but not greater than, the terminated coverages. Any probationary or waiting periods set forth in the policy are considered as being met to the extent coverage was in force under the prior policy.

SECTION 38-71-190. Subrogation of insurer to insured's rights against third party.

Any policy or contract of accident and health insurance issued in this State may include provision for subrogation by the insurer to the insured's right of recovery against a liable third party for not more than the amount of insurance benefits that the insurer has paid previously in relation to the insured's injury by the liable third party. If the director or his designee, upon being petitioned by the insured, determines that the exercise of subrogation by an insurer is inequitable and commits an injustice to the insured,

subrogation is not allowed. Attorneys' fees and costs must be paid by the insurer from the amounts recovered. This determination by the director or his designee may be appealed to the Administrative Law Judge Division as provided by law in accordance with Section 38-3-210.

SECTION 38-71-200. Discrimination forbidden; benefits for services of podiatrist, oral surgeon, or optometrist.

Discrimination between individuals of the same class in the amount of premiums or rates charged for a policy of insurance covered by this chapter, in the benefits payable on the policy, in terms or conditions of the policy, or in another manner is prohibited except as provided in Sections 38-57-140 and 38-71-1110. If a policy of insurance governed by this chapter provides for payment or reimbursement for a service which is within the scope of practice of a licensed podiatrist, licensed oral surgeon, licensed optometrist, or licensed doctoral psychologist, the insured or other person entitled to benefits under the policy is entitled to payment or reimbursement in accordance with the usual and customary fee for the services whether the services are performed by a licensed physician or a licensed podiatrist, a licensed oral surgeon, a licensed optometrist, or a licensed doctoral psychologist, notwithstanding a provision in the policy, and the policyholder, insured, or beneficiary may choose the provider of the services.

SECTION 38-71-210. Health insurance policies to include chiropractic services.

If an insurer offers a policy containing a provision for medical expense benefits that does not provide payment for chiropractic services, it shall offer as a part thereof an optional rider or endorsement, if specifically requested by the insured or subscriber under an individual policy or a certificate holder or subscriber under a master policy, which defines such benefits as including payment to a chiropractor for procedures specified in the policy which are within the scope of the practice of chiropractic. Any additional cost to the insured or certificate holder must be reasonably related to benefits provided.

SECTION 38-71-215. Dermatology referrals.

(A) If a primary care physician makes a referral to a dermatologist, the enrollee in a managed care plan may see the in-network dermatologist to whom the enrollee is referred, without further referral, for a minimum of six months or four visits, whichever first occurs, for diagnosis, medical treatment, or surgical procedures for the referral problem or related complications.

(B) Written communication from the dermatologist should be sent to the primary care physician after each visit.

(C) An enrollee with a documented past history of malignant melanoma may be referred by his or her primary care physician to an in-network dermatologist for an annual evaluation and, as necessary, biopsy or surgery, or both.

(D) All services provided pursuant to this section are subject to contractual provisions regarding medical necessity and benefit coverage.

(E) Nothing in this section may be construed to extend benefits to an enrollee past the contract period.

SECTION 38-71-220. Misrepresentations to induce termination or conversion of disability insurance policies.

No insurer, or its employee or agent, may make any misleading representations or incomplete or fraudulent comparisons of any disability insurance policies or insurers for the purpose of inducing, or which may tend to induce, any person to lapse, forfeit, surrender, terminate, return, or convert any disability insurance policy.

SECTION 38-71-230. Written notice of health insurance claim policies and procedures; adoption of standardized claim forms; addition of logo to form.

(A) All licensed health care providers are required to provide written notice of the policies and procedures with regard to health insurance claims. The notice may take the form of a patient information card or notice clearly posted in all patient waiting areas of the providers' place of business.

(B) An organization providing payment or reimbursement for diagnosis and treatment of a condition or a complaint by a licensed physician in South Carolina must accept the standardized HCFA 1500 claim form, or its successor as it may be amended from time to time. An organization providing payment or reimbursement for diagnosis and treatment of a condition or a complaint by a hospital licensed in South Carolina shall accept the standardized UB 82 claim form, or its successor as it may be amended from time to time.

(C) The HCFA 1500 or the UB 82 claim form or the successor of each or as either may be amended from time to time may be altered only with a customized logo which must appear in the top portion of the claim form one inch vertical from the top.

SECTION 38-71-240. Coverage required for cleft lip and palate; certain policies exempt.

(A) As used in this section:

(1) "Cleft lip and palate" means a congenital cleft in the lip or palate, or both.

(2) "Medically necessary care and treatment" shall include, but not be limited to:

(a) oral and facial surgery, surgical management, and follow-up care made necessary because of a cleft lip and palate;

(b) prosthetic treatment such as obturators, speech appliances, and feeding appliances;

(c) medically necessary orthodontic treatment and management;

(d) medically necessary prosthodontic treatment and management;

(e) otolaryngology treatment and management;

(f) audiological assessment, treatment, and management performed by or under the supervision of a licensed doctor of medicine, including surgically implanted amplification devices; and

(g) medically necessary physical therapy assessment and treatment.

(B)(1) Any individual or group accident and health policy which provides dependent coverage shall provide coverage for the medically necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of a cleft lip and palate. Such a policy may contain the same copayment provisions for the coverage of cleft lip and palate as apply to other conditions or procedures covered by the policy.

(2) Any individual or group dental policy which provides dependent coverage shall provide coverage for teeth capping, prosthodontics, and orthodontics necessary for the care and treatment of cleft lip and palate. Such a policy may contain the same copayment provisions for the coverage of cleft lip and palate as apply to other conditions or procedures covered by the policy.

(C) If a person with a cleft lip and palate is covered by an accident and health policy described in subsection (B)(1) and is also covered by a dental policy described in subsection (B)(2), teeth capping, prosthodontics, and orthodontics shall be covered by the dental policy to the limit of coverage provided and any excess thereafter shall be provided by the individual or group accident and health policy.

(D) The provisions of this section do not apply to a policy which provides disability or income protection coverage, hospital confinement indemnity coverage, accident only coverage, specified disease or specified accident coverage, long-term care coverage, vision only coverage, or coverage issued as a supplement to Medicare.

SECTION 38-71-241. Percentage copayment and deductible must be applied to negotiated rate or lesser charge of that provider.

An insurer that negotiates rates with providers for covered health care services under an individual or group accident and health insurance policy must provide that percentage copayments and deductibles paid by the insured are applied to the negotiated rates or lesser charge of that provider. Nothing in this section precludes an insurer from issuing a policy which contains fixed dollar copayments and deductibles.

SECTION 38-71-245. Prohibited grounds for denial of enrollment to child of health plan participant.

No health insurer, including a group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, may deny enrollment of a child under the health plan of the child's parent on the grounds that the child:

- (1) was born out of wedlock;
- (2) is not claimed as a dependent on the parent's federal tax return; or
- (3) does not reside with the parent or in the insurer's service area.

SECTION 38-71-250. Duties of insurer as to court-ordered health care coverage for child of eligible parent.

If, pursuant to a court order which meets the specifications of Section 20-7-1200, a parent is required to provide health coverage for a child and the parent is eligible for family health coverage through a health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, the insurer shall:

- (1) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;
- (2) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of:
 - (a) the child's other parent;
 - (b) the state agency administering the Medicaid program; or
 - (c) the state agency administering 42 U.S.C. Sections 651 to 669, the child support enforcement program;and
- (3) continue coverage of the child unless the insurer is provided satisfactory written evidence that the:
 - (a) court order is no longer in effect;
 - (b) child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
 - (c) employer has eliminated family health coverage for all of its employees.

SECTION 38-71-255. Health insurer may not impose different requirements on state agency.

A health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under Medicaid who is also covered under a plan issued by the health insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

SECTION 38-71-260. Duties of health insurer of child to custodial parent.

If a child has health coverage through the health insurer including a group health plan, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, of a noncustodial parent, the insurer shall:

- (1) provide information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

- (2) permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
- (3) make payments on claims submitted in accordance with item (2) directly to the custodial parent, the provider, or the state Medicaid agency.

SECTION 38-71-265. Health insurer not to consider State medical assistance; subrogation of state to right to insurance payment for health care.

(A) In enrolling a person or in making any payments for benefits to a person or on behalf of a person, no health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, may take into account that the person is eligible for or is provided medical assistance under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act.

(B) In a case where a health insurer, including a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 or health maintenance organization as defined in Section 38-33-20, has a legal liability to make payments for medical assistance to or on behalf of a person, to the extent that payment has been made under a State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act for health care items or services furnished to the person, the State is considered to have acquired the rights of the person to the payment for the health care items or services.

SECTION 38-71-275. Insurance coverage for certain drugs not to be excluded from policy definitions.

(A) No insurance policy which provides coverage for drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed; provided, that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

(B) This section shall not be construed to:

- (1) alter existing law with regard to provisions limiting the coverage of drugs that have not been approved by the Federal Food and Drug Administration;
- (2) require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contraindicated;
- (3) require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration;
- (4) create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

(C) For purposes of this section:

(1) "Insurance policy" means an individual, group, or blanket policy written by a medical expense indemnity corporation, a hospital service corporation, a health care service plan contract, or a private insurance plan issued, amended, delivered, or renewed in this State or which provides insurance for residents of this State.

(2) "Standard reference compendia" means:

- (a) the United States Pharmacopoeia Drug Information;
- (b) the American Medical Association Drug Evaluations; or
- (c) the American Hospital Formulary Service Drug Information.

(3) "Medical literature" means two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless one article from major peer-reviewed professional medical journals has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed.

SECTION 38-71-285. Task Force to Review State and Federal Health Insurance Mandates established; report and recommendations.

(A) As used in this section:

(1) "Mandated health benefit" means a benefit or coverage that is required by law to be offered or provided by a health insurance issuer and includes: coverage for specific health care services, treatments or practices; or the offering of specific health care services, treatments or practices.

(2) "Health insurance issuer" means any entity that provides health insurance coverage in this State.

(B) There is established the Task Force to Review State and Federal Health Insurance Mandates in South Carolina (task force). The task force consists of eleven members selected as follows:

(1) the Director of the Department of Insurance, or his designee;

(2) the Chairman of the Senate Committee on Banking and Insurance, or his designee;

(3) the Chairman of the House of Representatives Committee on Labor, Commerce and Industry, or his designee;

(4) the Director of the State Employees' Health Plan, or his designee;

(5) two members to be appointed by the Governor, one of whom must be a representative of a company that employs ten or fewer employees and one of whom must be a member of the general public who is not associated with health care providers; and

(6) five additional members selected by unanimous agreement of the members provided in items (1), (2), (3), and (4). These five members must have demonstrated expertise in health insurance and managed care issues; and

(a) two must be representatives of the health insurance industry, at least one of which being a representative of a domestic health insurance issuer;

(b) two must be representatives of the business community, at least one of which must be a representative of a company that employs fewer than fifty employees; and

(c) one must be a representative of the hospital industry.

Vacancies in the task force must be filled by appointment or selection, as applicable, in the manner of original appointment or selection. No business other than that necessary to establish the task force and select the additional members may be conducted until all eleven members have been appointed or selected and qualify. Staff and administrative support for the task force must be provided by the Department of Insurance and the State Employees' Health Plan in the manner the task force determines appropriate.

(C) The task force may hold public hearings, conduct research, receive the testimony of experts, review, for purposes of comparison, the mandated health benefits upon health insurance issuers in other states and jurisdictions and the effects of such mandates, and take other actions it determines appropriate for the completion of its assigned task. At a minimum, the task force shall inquire into and make recommendations with respect to:

(1) each and every state and federally mandated health benefit placed upon health insurance issuers in South Carolina since 1990;

(2) the impact of each such mandated health benefit on the premiums for health insurance coverage in South Carolina.

(D) The task force shall make a final report with recommendations to the General Assembly no later than January 1, 2005. Upon submission of the final report and recommendations, the task force is dissolved. Until such time as the task force makes its final report, mandated health benefits beyond those required as of January 1, 2002, may be imposed on a health insurance issuer doing business in this State only after review by the task force. Under no circumstances, however, is a mandate to be imposed prior to the first day of the second year after the effective date of the act.

(E) Nothing in this section shall be construed to prohibit any health insurance issuer from voluntarily expanding coverage or to prohibit any individual or employer from electing to expand coverage on any

health maintenance organization contract or individual or group health insurance policy or contract covering the individual, the employer, or employees of the employer as applicable.

(F) Nothing in this section shall be construed to prohibit amendments to comport with federal law.

SECTION 38-71-290. Mental health coverage; definitions; treatment requirements; exceptions

(A) As used in this section:

(1) "Health insurance plan" means a health insurance policy or health benefit plan offered by a health insurer or a health maintenance organization, including a qualified health benefit plan offered or administered by the State, or a subdivision or instrumentality of the State, that provides health insurance coverage as defined by Section 38-71-670(6).

(2) "Mental health condition" means the following psychiatric illnesses as defined by the "Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV)", and subsequent editions published by the American Psychiatric Association:

- (a) Bipolar Disorder;
- (b) Major Depressive Disorder;
- (c) Obsessive Compulsive Disorder;
- (d) Paranoid and Other Psychotic Disorder;
- (e) Schizoaffective Disorder;
- (f) Schizophrenia;
- (g) Anxiety Disorder;
- (h) Post-traumatic Stress Disorder; and
- (i) Depression in childhood and adolescence.

(3) "Rate, term, or condition" means lifetime or annual payment limits, deductibles, copayments, coinsurance and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of health insurance coverage that affects the insured.

(4) "Settings" means either emergency, outpatient, or inpatient care.

(5) "Modalities" means therapeutic methods or agents including, without limitation, surgery or pharmaceuticals.

(B) A health insurance plan must provide coverage for treatment of a mental health condition and may not establish a rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition in similar settings and treatment modalities. Any deductible or out-of-pocket limits required under a health insurance plan must be comprehensive for coverage of both mental health and physical health conditions.

(C) A health insurance plan that does not otherwise provide for management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization if the managed care organization is in compliance with regulations promulgated by the director. The regulations promulgated by the director must ensure that timely and appropriate access to care is available, that the quantity, location, and specialty distribution of health care providers is adequate, and that administrative or clinical protocols do not prevent access to medically necessary treatment for the insured.

(D) A health insurance plan complies with this section if at least one choice for treatment of mental health conditions provided to the insured within the plan has rates, terms, and conditions that place no greater financial burden on the insured than for access to treatment of physical conditions in similar settings and treatment modalities. The director may disapprove a plan that the director determines to be inconsistent with the purposes of this section.

(E) To be eligible for coverage under this section for the treatment of mental illness, the treatment must be rendered by a licensed physician, licensed mental health professional, or certified mental health professional in a mental health facility that provides a program for the treatment of a mental health condition pursuant to a written treatment plan. A health insurance plan may require a mental health

facility, licensed physician, or licensed or certified mental health professional to enter into a contract as a condition of providing benefits.

(F) The provisions of this section do not:

- (1) limit the provision of specialized medical services for individuals with mental health disorders;
- (2) supersede the provisions of federal law, federal or state Medicaid policy, or the terms and conditions imposed on a Medicaid waiver granted to the State for the provision of services to individuals with mental health disorders; or
- (3) require a health insurance plan to provide rates, terms, or conditions for access to treatment for mental illness that are identical to rates, terms, or conditions for access to treatment for a physical condition.

ARTICLE 3.

INDIVIDUAL ACCIDENT AND HEALTH POLICIES

SUBARTICLE 1.

POLICY FORMS AND RATES

SECTION 38-71-310. Filing of forms and rates; approval or disapproval; withdrawal of approval; exceptions; loss ratio guarantee.

(A) A policy or certificate of accident, health, or accident and health insurance may not be issued or delivered in this State, nor may any application, endorsement, or rider which becomes a part of the policy be used, until a copy of its form has been filed with and approved by the director or his designee, except as exempted by the director or his designee as permitted by Section 38-61-20. The director or his designee may disapprove the form if the form:

- (1) does not meet the requirements of law;
- (2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or
- (3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.

The director or his designee shall notify in writing, as soon as is practicable, the insurer that has filed the form of his approval or disapproval. If the form is disapproved, the notice must contain the reasons for disapproval, and the insurer is entitled to a public hearing on that decision. If action is not taken to approve or disapprove a policy or certificate, application, endorsement, or rider after the document has been filed for thirty days, it is deemed to be approved.

The director or his designee, in his discretion, may extend for up to an additional sixty days the period for approval or disapproval of the form. An organization may not use a form deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form. The notice must be filed in the office of the director at least ten days before the organization uses the form.

(B) No premium rates applicable to accident policies, health policies, or combined accident and health policies or certificates for individual or family protection may be used unless they have been filed with the department and approved by the director or his designee. The director or his designee may disapprove premium rates if he determines that the benefits provided in the policies or certificates are unreasonable in relation to the premiums charged. The director or his designee shall notify in writing the insurer, as soon as is practicable, which has filed the premium rates of his approval or disapproval with the department. In the event of disapproval, the notice must contain the reasons for disapproval, and the insurer is entitled to appeal the decision or determination of disapproval before the Administrative Law Judge Division as provided by law. If no action has been taken to approve or disapprove the premium rates after they have been filed for ninety days, they are deemed to be approved.

(C) At any time the director or his designee, after a public hearing of which at least thirty days' written notice has been given, may withdraw approval of forms or rates previously approved under subsections (A) and (B) if he determines that the forms or rates no longer meet the standards for approval specified in subsections (A) and (B).

(D) The provisions of this section do not apply to policies issued in connection with loans made under the Small Loan Act of 1966.

(E) For major medical expense coverage individual accident and health insurance policies, as defined by regulation of the department, the benefits are deemed reasonable in relation to the premium charged if the insurer has filed a loss ratio guarantee with the department. This guaranteed loss ratio must be equivalent to, or greater than, the most recent loss ratios detailed within the National Association of Insurance Commissioners' "Guidelines for Filing of Rates for Individual Health Insurance Forms." This loss ratio guarantee must be in writing and must contain at least the following:

(1) A recitation of the anticipated (target) loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved.

(2) A guarantee that the actual South Carolina loss ratios for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed will meet or exceed the loss ratio standards referred to in item (1) above.

(3) A guarantee that the actual South Carolina loss ratio results for the year at issue will be independently audited at the insurer's expense. This audit must be done in the second quarter of the next year and the audited results must be reported to the department not later than the date for filing the applicable Accident and Health Policy Experience Exhibit.

(4) A guarantee that affected South Carolina policyholders will be issued a proportional refund (based on premium paid) of the amount necessary to bring the actual aggregate loss ratio up to the anticipated loss ratio standards referred to in item (1) above. The refund must be made to all South Carolina policyholders insured under the applicable policy form as of the last day of the year at issue if the refund would equal five dollars or more. The refund must include statutory interest from the end of the year at issue until the date of payment. Payments must be made during the third quarter of the next year.

(5) As used herein, the term "loss ratio" means the ratio of incurred losses to earned premium by number of years of policy duration, for all combined durations.

(6) The reference in item (1) of this subsection to the "anticipated (target) loss ratio standards contained in the original actuarial memorandum filed with the policy form when it was originally approved" may not be considered or construed as evidence of legislative intent that the use of, or adherence to, such "anticipated (target) loss ratio standards" is approved or disapproved in any application for a rate increase for any policy form approved prior to the effective date of these amendments to Section 38-71-310.

(F) Nothing in this chapter precludes the issuance of an individual accident, health, or accident and health insurance policy that includes an optional life insurance rider. However, the optional life insurance rider must be filed with and approved by the director or his designee pursuant to Section 38-61-20 and comply with all applicable sections of Chapter 63 and, in addition, in the case of a life insurance rider with accelerated long term care benefits, Chapter 72 of this title.

SECTION 38-71-315. Decrease of premium charges.

Any insurer of individual accident and health insurance may at any time, except when required by law or order of the director or his designee, voluntarily decrease its premium charge for any approved policy form without the prior approval of the director or his designee. However, the insurer must notify the director or his designee and the consumer advocate for information thirty days prior to the use of the revised premium charge. Notwithstanding any other provision of law, any time within one year after using such revised premium charge, the insurer may return its premium charge back to the previously approved level by informing the director or his designee and the consumer advocate of the revision thirty days prior to the effective date. The director or his designee may not disapprove such revision.

SECTION 38-71-320. Policies issued for delivery in another state.

If a policy is issued by an insurer domiciled in this State for delivery to a person residing in another state and if the official having responsibility for the administration of the insurance laws of the other state has advised the director or his designee that the policy is not subject to approval or disapproval by the official, the director or his designee may by ruling require that the policy meet the standards set forth in Sections 38-71-330, 38-71-340, and 38-71-370.

SECTION 38-71-325. Requirements for approval of new individual major medical expense coverage policies.

On January 1, 1992, in addition to any other requirements of law, no new individual major medical expense coverage policy, as defined in regulations promulgated by the department, may be approved unless:

(1) Premium rates, after appropriate allowance for the actuarial value of the difference in benefits, for any such policy form first approved for use by the insurer in South Carolina within the two-year period immediately prior to the effective date of this section and any such policy form first approved for use after the effective date of this section do not exceed the premium rates for any other such policy form first approved for use during this period by more than thirty percent.

(2) The actuarial value of the difference in benefits set out in such policy forms of the insurer, as specified in an opinion by a qualified actuary or other qualified person acceptable to the director or his designee, is reported not less often than once a year to the director or his designee and used in demonstrating compliance with item (1) above.

(3) The anticipated (target) loss ratio for the combined experience for all the policy forms specified in item (1) must be equivalent to or greater than the most recent loss ratios detailed within the National Association of Insurance Commissioner's 'Guidelines for Filing of Rates for Individual Health Insurance Forms' or successor publications. The anticipated (target) loss ratio for the combined experience is defined as the average anticipated (target) loss ratio for all these policy forms included in the combined experience weighted by premium volume. With respect to the policy form, the insurer shall have the right to file a loss ratio guarantee in accordance with the procedures specified in Section 38-71-310(E) or to request approval of any rate change before the use thereof, but the anticipated loss ratios of each policy form whether or not a loss ratio guarantee has been filed must be combined as provided in the preceding item (3).

The initial policy form proposed to be used by a domestic insurer after its organization under the laws of this State and the initial policy form proposed to be used by a foreign insurer after authorization by the director or his designee to do business in this State may be disapproved by the director or his designee if he determines that the rates proposed to be used with the policy form are set at a level substantially less than rates charged by other insurers in this State offering comparable coverage.

Nothing contained in this section may be construed to prevent the use of age, sex, area, industry, occupational, and avocational factors or to prevent the use of different rates for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person and are approved by the director or his designee. Also, nothing contained in this section shall preclude the establishment of a substandard classification based upon the health condition of the insured, but the initial classification may not be changed adversely to the applicant after initial issue.

The director or his designee has the right, upon application by any insurer, to grant relief, for good cause shown, from any requirement of this section.

SECTION 38-71-330. Form of policies.

No policy of accident and health insurance may be delivered or issued for delivery to any person in this State unless:

- (1) The entire money and other considerations therefor are expressed therein.
- (2) The time at which the insurance takes effect and terminates is expressed therein.
- (3) It purports to insure only one individual, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is considered the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children under a specified age which may not exceed nineteen years, and any other individual dependent upon the policyholder.
- (4) The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one-hundred-and-twenty-point (the "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions).
- (5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Sections 38-71-340 and 38-71-370, are printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.
- (6) Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page thereof.
- (7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or short-rate table filed with the department.

SECTION 38-71-335. Accident and/or health insurance cancellation provision prohibited; optionally renewable policies prohibited; notice of nonrenewal.

(A) No individual or family accident, health, or accident and health insurance policy may contain a provision which gives the insurer the right to cancel the policy. "To cancel" means to terminate a policy at a date other than the policy anniversary date or the premium due date.

(B) For individual or family accident, health, or accident and health insurance policies, excluding individual health insurance coverage as defined in Section 38-71-670, individual or family accident, health, or accident and health insurance policies may not be written on an optionally renewable basis. "Optionally renewable" means a contract of insurance in which the insurer reserves the right to terminate the coverage at the policy anniversary date. Optionally renewable does not include the following categories of policies as defined by the department by regulation: (1) "nonrenewable for stated reasons only" and (2) "conditionally renewable". Term insurance is not considered insurance written on an optionally renewable basis. For individual health insurance coverage as defined in Section 38-71-670, Section 38-71-675 relating to guaranteed renewability of individual health insurance coverage shall apply.

(C) An individual or family accident, health, or accident and health insurance policy which may be nonrenewed, may be nonrenewed at the policy anniversary date or premium due date. The insurer shall give the insured at least thirty-one days' written notice of nonrenewal. Nonrenewal by the insurer is without prejudice to any claims originating before the effective date of nonrenewal. No written notice shall be required for failure to pay premiums except as provided in Section 38-71-110. For individual health insurance coverage as defined in Section 38-71-670, the notification requirements of Section 38-71-675(C) shall apply.

SECTION 38-71-340. Required provisions.

Except as provided in Section 38-71-410, each accident, health, or accident and health policy delivered or issued for delivery to an individual in this State must contain the provisions specified in this section, in the words in which they appear in this section. The insurer, at its option, may substitute for one or more of these provisions corresponding provisions of different wording approved by the director or his designee which are in each instance not less favorable in any respect to the insured or the beneficiary. These provisions must be preceded individually by the caption appearing in this section or, at the option of the insurer, by appropriate individual or group caption or subcaptions approved by the director or his designee.

(1) A provision as follows:

ENTIRE CONTRACT; CHANGES:

This policy, with the application and attached papers, if any, is the entire contract between the insured and the company.

No change in this policy is effective until approved by a company officer. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

(2) A provision as follows:

TIME LIMIT ON CERTAIN DEFENSES:

After two years from the issue date only fraudulent misstatements in the application may be used to void the policy or deny any claim for loss incurred or disability that starts after the two-year period.

A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty or (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parenthesis may be omitted at the insurer's option) "INCONTESTABLE":

(a) Misstatements in the application:

After this policy has been in force for two years during the insured's lifetime (excluding any period during which the insured is disabled), the company cannot contest the statements contained in the application.

(b) Preexisting conditions:

No claim for loss incurred or disability that starts after two years from the issue date will be reduced or denied because a sickness or physical condition not excluded by name or specific description before the date of loss had existed before the effective date of coverage.

(3) A provision as follows:

GRACE PERIOD:

This policy has a ____ day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following ____ days. During the grace period the policy will stay in force. [Note: Insert a number not less than "seven" for weekly premium policies, "ten" for monthly premium policies, and "thirty-one" for all other policies.]

(4) A provision as follows:

REINSTATEMENT:

If the renewal premium is not paid before the grace period ends the policy will lapse. Later acceptance of the premium by the company or by an agent authorized to accept payment without requiring an application for reinstatement will reinstate the policy. If the company or its agent requires an application, the insured will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the forty-fifth day after the date of the conditional receipt unless the company has previously written the insured of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement or sickness that starts more than ten days after such date.

In all other respects the rights of the insured and the company will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premiums the company accepts for reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty days before the reinstatement date.

[The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue.]

(5) A provision as follows:

NOTICE OF CLAIM:

Written notice of claim must be given within twenty days after a covered loss starts or as soon as reasonably possible. The notice may be given to the company at its home office or to the company's agent. Notice should include the name of the insured and the policy number.

Optional paragraph: If the insured has a disability for which benefits may be payable for at least two years, at least once every six months after the insured has given notice of claim, the insured shall give the company notice that the disability has continued. The insured need not do this if legally incapacitated. The first six months after any filing of proof by the insured or any payment or denial of a claim by the company will not be counted in applying this provision.

If the insured delays in giving this notice, the insured's right to any benefits for the six months before the date when the insured gives notice will not be impaired.

(6) A provision as follows:

CLAIM FORMS:

When the company receives notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within fifteen days the claimant will meet the proof of loss requirements by giving the company a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss section.

(7) A provision as follows:

PROOFS OF LOSS:

If the policy provides for periodic payment for a continuing loss, written proof of loss must be given the company within ninety days after the end of each period for which the company is liable. For any other loss, written proof must be given within ninety days after such loss. If it was not reasonably possible to give written proof in the time required, the company may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

(8) A provision as follows:

TIME OF PAYMENT OF CLAIMS:

After receiving written proof of loss, the Company will pay ____ [insert period for payment which may not be less frequently than monthly] all benefits then due for ____ [insert applicable term for type of benefits].

(9) A provision as follows:

PAYMENT OF CLAIMS:

Benefits will be paid to the insured. Loss of life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the insured's estate. Any other benefits unpaid at death may be paid, at the company's option, either to the insured's beneficiary or estate.

Optional paragraph: If benefits are payable to the insured's estate or a beneficiary who cannot execute a valid release, the company can pay benefits up to one thousand dollars to someone related to the insured or beneficiary by blood or marriage whom the company considers to be entitled to the benefits. The company will be discharged to the extent of any such payment made in good faith.

Optional paragraph: The company may pay all or a portion of any indemnities provided for health care services to the provider, unless the insured directs otherwise in writing by the time proofs of loss are filed. The company cannot require that the services be rendered by a particular provider.

(10) A provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY:

The company at its own expense may have the insured examined as often as reasonably necessary while a claim is pending and in cases of death of the insured the insurer at its own expense also may have an

autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

(11) A provision as follows:

LEGAL ACTIONS:

No legal action may be brought to recover on this policy within sixty days after written proof of loss has been given as required by this policy. No such action may be brought after six years from the time written proof of loss is required to be given.

(12) A provision as follows:

CHANGE OF BENEFICIARY:

The insured can change the beneficiary at any time by giving the company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

(13) A provision as follows:

CONFORMITY WITH STATE STATUTES:

Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of such laws.

SECTION 38-71-350. Required provision for continuation of coverage for handicapped and dependent children of policyholder.

An individual hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, so long as proof of the incapacity and dependency is furnished to the insurer by the policyholder or subscriber within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

SECTION 38-71-360. Continuation of coverage for nonhandicapped dependent children.

An individual hospital, medical, or surgical expense incurred insurance policy, hospital service plan contract, or medical service plan contract, other than a limited classification policy, delivered or issued for delivery in this State which provides that coverage of a nonhandicapped dependent child terminates upon attainment of the limiting age for the child as specified in the policy or contract shall also contain a provision to the effect that upon the attainment of the limiting age the child is entitled to have issued to him, without evidence of insurability, upon application made to the insurer within thirty days following the attainment of the age, and upon payment of the appropriate premium, an individual policy of accident and health insurance. The policy shall provide the coverage then being issued by the insurer which is closest to, but not greater than, the terminated coverage. Any probationary or waiting period set forth in the policy must be considered as met to the extent coverage was in force under the prior policy. For purposes of this section, "limited classification policy" means an accident-only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

SECTION 38-71-370. Optional provisions.

Except as provided in Section 38-71-410, no individual accident, health, or accident and health policy delivered or issued for delivery to any person in this State may contain provisions respecting the matters

set forth below unless the provisions are in the words in which they appear in this section. However, the insurer may, at its option, use in lieu of these provisions a corresponding provision of different wording approved by the director or his designee which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section, or, at the option of the insurer, by appropriate individual or group captions or subcaptions approved by the director or his designee.

(1) A provision as follows:

CHANGE OF OCCUPATION:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent.

In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) A provision as follows:

MISSTATEMENT OF AGE:

If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

(3) A provision as follows:

OTHER INSURANCE IN THIS INSURER:

If the insured has more than one policy _____ [insert designation for limitation such as policy form-type-form], only one policy chosen by the insured will be effective. The company shall refund all premiums paid for all the other policies.

Optional paragraph: If the insured has more than one policy with this company providing a total indemnity for _____ [insert type of coverage or coverages] of more than _____ [insert maximum limit of indemnity or indemnities] the excess insurance is void. The premiums paid for the excess must be returned to the insured.

Or, in lieu thereof:

Insurance effective at one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary, or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

On every application for insurance the insurer shall ask for the amount of insurance which the applicant currently has in force with such insurer. If the insurer fails to ascertain the amount of insurance which an applicant has in force, all policies issued by the insurer to the applicant remain in force and the insurer is liable for all benefits payable thereunder, unless the applicant has misrepresented the amount of existing coverage on the application.

In all cases where the applicant indicates that other life, accident, and health insurance is in force with the insurer or the insurer's company, the insurer shall provide the applicant with the total amount of existing coverage with the insurer or insurer's company within sixty days.

(4) A provision as follows:

INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision-of-service basis or on an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

[If the foregoing policy provision is included in a policy which also contains the policy provision set out in item (5) of this section, there shall be added to the caption of the foregoing provision the phrase "EXPENSE-INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and by hospital or medical service organizations and to any other coverage the inclusion of which may be approved by the director or his designee. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations.

For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".]

(5) A provision as follows:

INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss and for the return of such portion of the premium paid as shall exceed the pro ratio portion for the indemnities thus determined.

[If the foregoing policy provision is included in a policy which also contains the policy provision set out in item (4) of this section, there shall be added to the caption of the foregoing provision the phrase "OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage" approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director or his designee. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations.

For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".]

(6) A provision as follows:

RELATION OF EARNINGS TO INSURANCE:

If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro ratio amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. [The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of the premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss-of-time coverage", approved as to form by the director or his designee, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada or to any other coverage the inclusion of which may be approved by the director or his designee or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organization.]

(7) A provision as follows:

UNPAID PREMIUM:

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

(8) A provision as follows:

ILLEGAL OCCUPATION:

The company is not liable for any loss which results from the insured committing or attempting to commit a felony or from the insured engaging in an illegal occupation.

(9) A provision as follows:

INTOXICANTS AND NARCOTICS:

The company is not liable for any loss resulting from the insured being drunk or under the influence of any narcotic unless taken on the advice of a physician.

SECTION 38-71-410. Omission or modification of required or optional provisions.

If any provision of Sections 38-71-340 and 38-71-370 is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director or his designee, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision in a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

SECTION 38-71-420. Placement of required and optional provisions in policy.

The provisions which are the subject of Sections 38-71-340 and 38-71-370, or any corresponding provisions which are used in lieu thereof in accordance with those sections, must be printed in the consecutive order of the provisions in those sections, or, at the option of the insurer, any such provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, as

long as the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

SECTION 38-71-430. Additional provisions may not make policy less favorable.

A policy provision which is not subject to Sections 38-71-340 and 38-71-370 may not make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions which are subject to either of these sections.

SECTION 38-71-440. HMO's and health benefit plans offering medical eye care or vision care benefits; prohibited actions.

(A) As used in this section:

(1) "Health benefit plan" means any public or private health plan implemented in this State that provides medical eye care or vision care benefits, or both, to covered persons including payments and reimbursements.

(2) "Ophthalmologist" means a physician licensed pursuant to Title 40, Chapter 47 who practices in South Carolina and who specializes in the medical and surgical care of the eye and visual system and routine vision care.

(3) "Optometrist" means a doctor of optometry licensed pursuant to Title 40, Chapter 37 who is engaged in the practice of optometry in South Carolina.

(B) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, shall prohibit a participating optometrist from performing medical services within that optometrist's scope of practice set forth in Title 40, Chapter 37, in accordance with the terms of the health maintenance organization or health benefit plan and in accordance with subsections (C) and (I).

(C) No health maintenance organization or health benefit plan which maintains or contracts with a network of ophthalmologists or optometrists, or both, to provide medical eye care or vision care benefits, or both, excepting all self-funded health benefit plans as defined under the Federal Employee Retirement Income Security Act (ERISA) of 1974, shall discriminate against optometry, as a class, or ophthalmology, as a class, with respect to the terms, conditions, privileges, and opportunity of participation or compensation for the same eye care services provided in this section.

(D) No health benefit plan or health maintenance organization shall impose on optometry, as a class, any condition or restriction which is not necessary for the delivery of services or materials, or both, in accordance with and subject to Chapter 37, Title 40.

(E) Any health maintenance organization or health benefit plan may contract for vision care benefits or medical eye care benefits, or both. A health maintenance organization or health benefit plan may contract for surgery only services with ophthalmologists. A health maintenance organization or health benefit plan must be authorized to contract with optometrists and ophthalmologists as either individual panelists or network panelists.

(F) Nothing in this section may be construed to limit, expand, or otherwise affect the scope of practice of optometrists and therapeutically certified optometrists as provided for in Chapter 37, Title 40.

(G) Nothing in this section may be construed to preclude a covered person from receiving emergency medical eye care or to preclude a primary care physician from providing treatment for covered services in accordance with the terms of a health maintenance organization or health benefit plan.

(H) Nothing in this section may be construed to mandate coverage of any service.

(I) Nothing in this plan may be construed to prohibit a health maintenance organization or health benefit plan from professionally credentialing and evaluating all individual optometrists or ophthalmologists within a network or plan in a nondiscriminatory manner. Nothing in this section may be construed to prohibit any health maintenance organization or health benefit plan from limiting the number of optometrists or ophthalmologists in a nondiscriminatory manner or to prohibit a health maintenance

organization or health benefit plan from negotiating individually with optometrists or ophthalmologists for individual rates and eye care services in a nondiscriminatory manner.

(J) Any person aggrieved by a violation of this section may file a complaint with the Department of Insurance. After notice to the health maintenance organization or health benefit plan and an opportunity for it to submit a written response to the complaint, the director of the department may make a written determination regarding the complaint. Any party aggrieved by the director's determination is entitled to administrative and judicial review pursuant to Article 3, Chapter 23, Title 1. The director or the administrative law judge, if a hearing before the Administrative Law Judge Division is requested, may impose sanctions that are authorized under current insurance laws if a violation of this section is found to have occurred.

SUBARTICLE 3.

STANDARDIZATION AND SIMPLIFICATION OF TERMS AND COVERAGES

SECTION 38-71-510. Declaration of purpose.

The purpose of this subarticle is to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies or subscriber contracts of nonprofit hospital, medical, and dental service associations in order to facilitate public understanding and comparison, to eliminate provisions contained in individual accident and health insurance policies or subscriber contracts of nonprofit hospital, medical, and dental service associations which may be misleading or unreasonably confusing in connection with the purchase of the coverage or with the settlement of claims, to provide for full disclosure in the sale of accident and health coverages, and to provide for the termination of approval, after due notice and hearing before the director or his designee, of policy forms which do not comply with the minimum standards. Any decision or determination by the director or his designee to terminate approval pursuant to the administrative hearing may be appealed to the Administrative Law Judge Division as provided in accordance with Section 38-3-210.

SECTION 38-71-520. Definitions.

As used in this subarticle, unless the context clearly indicates otherwise, the following words or phrases have the following meaning:

- (1) "Form" means policies, contracts, riders, endorsements, and applications as provided in Section 38-71-310.
- (2) "Accident and health insurance" means insurance written under this article, other than credit accident and health insurance.
- (3) "Policy" means the entire contract between the insurer and the insured, including the policy, riders, endorsements, and the application, if attached, and also includes subscriber contracts issued by nonprofit hospital, medical, and dental service associations.

SECTION 38-71-530. Regulations establishing specific standards that set forth manner, content, and required disclosure for sale of individual policies.

(a) The department shall promulgate regulations to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of individual policies of accident and health insurance or subscriber contracts of nonprofit hospital, medical, and dental service associations which must be in addition to and in accordance with applicable laws of this State and which may cover, but are not limited to, the following:

- (1) Terms of renewability.
- (2) Initial and subsequent conditions of eligibility.

- (3) Nonduplication of coverage provisions.
- (4) Coverage of dependents.
- (5) Preexisting conditions.
- (6) Termination of insurance.
- (7) Probationary periods.
- (8) Limitations.
- (9) Exceptions.
- (10) Reductions.
- (11) Elimination periods.
- (12) Requirements for replacement.
- (13) Recurrent conditions.
- (14) The definition of terms including, but not limited to, the following:
 - (i) Hospital.
 - (ii) Accident.
 - (iii) Sickness.
 - (iv) Injury.
 - (v) Physician.
 - (vi) Accidental means.
 - (vii) Total disability.
 - (viii) Partial disability.
 - (ix) Nervous disorder.
 - (x) Guaranteed renewable.
 - (xi) Noncancelable.
- (b) The department may promulgate regulations that specify prohibited policy provisions not otherwise specifically authorized by law which in the opinion of the director or his designee are unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary.

SECTION 38-71-540. Regulations establishing minimum standards for benefits.

- (a) The department shall promulgate regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies of accident and health insurance or subscriber contracts of nonprofit hospital, medical, and dental service associations, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy:
 - (1) basic hospital expense coverage;
 - (2) basic medical-surgical expense coverage;
 - (3) hospital confinement indemnity coverage;
 - (4) major medical expense coverage;
 - (5) disability income protection coverage;
 - (6) accident-only coverage; and
 - (7) specified disease or specified accident coverage.
- (b) This section does not preclude the issuance of any policy or contract which combines two or more of the categories of coverage enumerated in items (1) through (6) of subsection (a) of this section.
- (c) No policy or contract may be delivered or issued for delivery in this State which does not meet the prescribed minimum standards for the categories of coverage listed in items (1) through (7) of subsection (a) of this section which are contained within the policy or contract unless the director or his designee finds the policy or contract will be in the public interest and the policy or contract meets the requirements set forth in Section 38-71-310.
- (d) The department shall by regulation prescribe the method of identification of policies and contracts based upon coverages provided.

SECTION 38-71-550. Outline of coverage required.

(a) In order to provide for full and fair disclosure in the sale of individual accident and health insurance policies or subscriber contracts of a nonprofit hospital, medical, or dental service association, no such policy or contract may be delivered or issued for delivery in this State unless, in the case of a direct response insurance product, the outline of coverage described in subsection (b) of this section accompanies the policy and, in all other cases, the outline of coverage described in subsection (b) is delivered to the applicant at the time application is made and an acknowledgment of receipt or certificate of delivery of the outline is provided the insured with the application. In the event the policy is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract shall accompany the policy or contract when it is delivered and clearly state that it is not the policy or contract for which application was made.

(b) The department shall by regulation prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this subsection (b), 'format' means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage shall include:

(1) A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in Section 38-71-540.

(2) A description of the principal benefits and coverage provided in the policy or contract.

(3) A statement of the exceptions, reductions, and limitations contained in the policy or contract.

(4) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums.

(5) A statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

SECTION 38-71-560. Effect of use of simplified application form.

Notwithstanding the provisions of item (2) of Section 38-71-340 or any other provision of law, if an insurer elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy shall cover any loss occurring after twelve months from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract may not include wording that would permit a defense based upon preexisting conditions.

SUBARTICLE 5.

GENERAL PROVISIONS

SECTION 38-71-610. Notice of premiums due required.

(1) All insurers issuing accident or health policies, or combinations thereof, in this State, where the premiums on the policies are collected directly by mail on a quarterly, semiannual, or annual basis, shall give a written notice to the policyholders of any premium due on the policies at least ten days prior to the due date. No premium is considered past due on the policies unless the policyholder has been given this notice and the policy remains in full force and effect until the expiration of the ten-day period after notice has been given. In the event the premium is not paid upon first notice at least ten days prior to lapsing of the policy a second notice must be forwarded to the insured. Nothing contained in this section applies to the following kinds of health and accident policies: debit accident insurance, debit health insurance, debit accident and health insurance, group accident and health insurance, franchise accident and health insurance, salaries savings accident and health insurance, credit accident and health insurance, accident

and health insurance where premiums are paid by bank draft or preauthorized check service, and blanket insurance.

(2) This section may not be construed to relieve any policyholder from paying any premium or portion thereof, nor may it be construed so as to prevent termination for any other valid reason.

SECTION 38-71-620. Advance notice required for increase in premium.

If an accident and health insurance policy contains provisions which reserve the right to the insurer to increase the premium, the policy shall also provide that at least thirty-one days' prior written notice of a rate increase must be given to the insured before the rate increase becomes effective.

SECTION 38-71-630. Acceptance of premium for period beyond expiration date of policy.

If any accident, health, or accident and health policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after the date, the coverage provided by the policy must continue in force until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

SECTION 38-71-640. Person with insurable interest may take out policy on insured.

The term "insured" as used in this article may not be construed as preventing a person other than the insured, with a proper insurable interest, from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

SECTION 38-71-650. Right to transfer to policy of equal or lesser benefits with same insurer.

Any person purchasing an individual accident, health, or accident and health insurance policy after July 1, 1991, shall have the right to transfer to any individual policy of equal or lesser benefits offered for sale by the insurer at the time the transfer is sought. Any special provision excluding coverage for a specified condition may remain after transfer, and any waiting period or preexisting condition period specified in the policy to which the transfer is made may be required to be served after the transfer.

SUBARTICLE 7.

REQUIREMENTS FOR ISSUERS AND INDIVIDUAL HEALTH INSURANCE COVERAGE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

SECTION 38-71-670. Definitions.

As used in this subarticle:

(1) "Bona fide association" means, with respect to health insurance coverage offered in the State, an association which:

(a) has been actively in existence for at least 5 years;

(b) has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members, or individuals eligible for coverage through a member;

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(f) meets such additional requirements as may be imposed under state law.

(2) "Director of Insurance" or "director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. "Director" also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by the director in managing or supervising the Department of Insurance.

(3) "Employee" has the meaning given the term under Section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) "Employer" has the meaning given the term under Section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term shall include only employers of two or more employees.

(5) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(6) "Health insurance coverage" means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:

(a) coverage only for accident or disability income insurance or any combination of these;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for on-site medical clinics;

(h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) if offered separately:

(i) limited scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;

(iii) other similar, limited benefits as are specified in regulations;

(j) if offered as independent, noncoordinated benefits:

(i) coverage only for a specified disease or illness;

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;

(ii) coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; and

(iii) similar supplemental coverage under a group health plan.

(7) "Health insurance issuer" or "issuer" means any entity that provides health insurance coverage in this State. For purposes of this subarticle, "issuer" includes an insurance company, a health maintenance

organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(8) "Health maintenance organization" means an organization as defined in Section 38-33-20(7).

(9) "Health status-related factor" means any of the following factors in relation to the individual or a dependent of the individual: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.

(10) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(11) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the State elects to regulate the coverage as coverage issued to small employers, as defined in Section 38-71-1330.

(12) "Large group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by an employer that is not a small employer, as defined in Section 38-71-1330.

(13) "Medical care" means amounts paid for:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and

(c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).

(14) "Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(15) "Participant" has the meaning given the term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

(16) "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer, as defined in Section 38-71-1330.

SECTION 38-71-675. Renewal or continuance of coverage at option of insurer; conditions for nonrenewal or discontinuance; modification of coverage.

(A) Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

(B) A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) the issuer is ceasing to offer coverage in the individual market in accordance with subsection (C) and applicable state law;

(4) with the approval of the director or his designee, in the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the issuer is authorized to do business but only if the coverage is terminated under this item uniformly without regard to any health status-related factor of covered individuals;

(5) with the approval of the director or his designee, in the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association, on the basis of which the coverage is provided, ceases but only if the coverage is terminated under this item uniformly without regard to any health status-related factor of covered individuals.

(C)(1) In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if the issuer:

(a) provides notice to each covered individual provided coverage of this type in the market of the discontinuation at least ninety days before the date of the discontinuation of the coverage;

(b) offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subitem (b), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(2)(a) Subject to subitem (c), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in this State, health insurance coverage may be discontinued by the issuer only if:

(i) the issuer provides notice to the director and to each individual of the discontinuation at least one hundred eighty days before the date of the expiration of the coverage; and

(ii) all health insurance issued or delivered for issuance in the State in the market is discontinued and coverage under the health insurance coverage in the market is not renewed.

(b) In the case of a discontinuation under subitem (a) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

(E) In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an "individual" is deemed to include a reference to such an association of which the individual is a member.

SECTION 38-71-680. Application of Section 38-71-850(D).

Section 38-71-850(D) applies to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

ARTICLE 5.

GROUP ACCIDENT AND HEALTH INSURANCE

SUBARTICLE 1.

GENERAL PROVISIONS

SECTION 38-71-710. Definitions.

(1) "Employees" as used in this article includes, for the purposes of insurance hereunder, as employees of a single employer, the officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporate employer and the individual proprietors, partners, and employees of individuals and firms the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The policy or contract may provide that the term "employees" includes retired employees.

(2) "Employer" as used in this article may include any municipal corporation or the proper officers, as such, of any unincorporated municipality or any department of the municipal corporation or unincorporated municipality determined by conditions pertaining to the employment.

(3) A "group accident insurance policy" is a policy or contract of insurance against death or injury resulting from accident or from accidental means which covers more than one person, except blanket accident policies, family accident policies, and accident and health policies.

(4) A "group accident and health policy" is a policy or contract which combines the coverage of group accident insurance and of group health insurance.

(5) A "group health insurance policy" is a policy or contract which insures against disablement, disease, or sickness of the insured, excluding disablement which results from accident or from accidental means, which covers more than one person, except blanket health policies, family health policies, franchise health policies, and accident and health policies.

SECTION 38-71-720. Approval of forms required; refusal or withdrawal of approval; optional life insurance riders.

(A) A policy or contract of group accident, group health, or group accident and health insurance may not be issued or delivered in this State, nor may any application, endorsement, or rider which becomes a part of the policy be used, until a copy of the form has been filed with and approved by the director or his designee except as exempted by the director or his designee as permitted by Section 38-61-20. The director or his designee may disapprove the form if the form:

(1) does not meet the requirements of law;

(2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or

(3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.

If action is not taken to approve or disapprove a policy, contract, certificate, application, endorsement, or rider after the document has been filed for thirty days, it is deemed to be approved. The director or his designee, in his discretion, may extend for up to an additional sixty days the time period for approval or disapproval of the form. An organization may not use a form deemed approved pursuant to the default provision of this section until the organization has filed with the director or his designee a written notice of its intent to use the form. The notice must be filed in the office of the director at least ten days before the organization uses the form. The director or his designee, as soon as is practicable, shall notify in writing the insurer which has filed the form of his approval or disapproval. If the form is disapproved, the notice must contain the reasons for disapproval and the insurer is entitled to a public hearing on that decision. At any time after having given written approval, the director or his designee, after a public hearing of which at least thirty days' written notice has been given, may withdraw approval if he finds that the form:

(1) does not meet the requirements of law;

(2) contains provisions which are unfair, deceptive, ambiguous, misleading, or unfairly discriminatory; or

(3) is solicited by means of advertising, communication, or dissemination of information which is deceptive or misleading.

The withdrawal of approval must be effected by written notice to the insurer and the insurer is entitled to a public hearing on that decision. Any action or decision of the director or his designee to withdraw approval may be appealed to the Administrative Law Judge Division in accordance with Section 38-3-210.

(B) Nothing in this chapter precludes the issuance of a policy or contract of group accident, group health, or group accident and health insurance that includes an optional life insurance rider. However, the optional life insurance rider must be filed with and approved by the director or his designee pursuant to Section 38-61-20 and comply with all applicable sections of Chapter 65 and, in addition, in the case of a life insurance rider with accelerated long term care benefits, Chapter 72 of this title.

SECTION 38-71-730. Requirements for group accident, group health, and group accident and health policies.

No policy of group health, group accident, or group accident and health insurance may be delivered or issued for delivery in this State unless it conforms to the following description:

(1) Except as provided in this item, the policy is issued to a trust or to insure two or more persons who are associated in a common group for purposes other than the obtaining of insurance.

(a) Group policies of credit accident and health insurance may be issued to persons other than those in a common group.

(b) A common group of small employers may be formed solely for the purpose of obtaining insurance. Such a group must comply with the following provisions:

(i) It contains at least one thousand eligible employees.

(ii) It establishes requirements for membership. However, the common group cannot exclude any small employer, which otherwise meets the requirements for membership, on the basis of claim experience or any health status-related factors, as defined in Section 38-71-840, in relation to the employee or a dependent of the employee.

(iii) It holds an open enrollment period at least once a year during which new members can join the common group.

(iv) It allows eligible employees and their dependents, upon initial enrollment and during subsequent open enrollment periods, to choose among health insurance plans offered through the group. Persons covered by a health insurance plan offered through the group which requires an enrollment period in excess of one year are eligible to choose among available plans upon the completion of the enrollment period.

(v) It offers coverage under all plans offered through the group to all eligible employees of member small employers and their dependents. Coverage may not be offered only to certain employees of member small employers and their dependents except as provided in Section 38-71-1370(B) of this chapter.

(vi) It does not assume any risk or form self-insurance plans among its members unless it complies with the provisions of Chapter 41 of this title.

(vii) It has the option of using any type of rating arrangement with the health insurance plans and, at its discretion, premiums may be paid to the health insurance plans by the common group, by member small employers, or by eligible employees and their dependents.

(A) Health insurance plans offered through the common group which rate each member small employer separately are subject to the laws governing small employer health insurance; and

(B) Health insurance plans offered through the common group which rate the entire group as a whole must charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by Section 38-71-940 and plan selection, and are subject to the laws governing group accident and health insurance.

(viii) It may not act as an agent or engage in any activities for which an insurance agent's license is required.

(ix) Before offering any health insurance plans through the common group, and annually thereafter, it registers with the department and demonstrates continued compliance with the subitems (b)(i) through (viii).

(2) The benefits provided by the policy are based on some plan or plans precluding individual selection, except that insurance supplemental to the basic coverage may be available to persons insured under the policy.

(3) For all groups, no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within thirty-one days thereafter. Nothing in this section precludes the obtaining of medical information with respect to the members of the group for use in determining the insurability of the group, but the information may not be used to exclude an individual from coverage. In addition, group health insurance coverage, as defined in Section 38-71-840 must adhere to the requirements of Section 38-71-860 prohibiting discrimination against individual participants and beneficiaries based on health status-related factors.

(4) Except for group health insurance coverage as defined in Section 38-71-840, the policies may contain a provision limiting coverage for preexisting conditions. The preexisting conditions must be covered no later than twelve months without medical care, treatment, or supplies ending after the effective date of the coverage or twelve months after the effective date of the coverage, whichever occurs first. Policies of disability income insurance may exclude coverage for disabilities beginning during the first twelve months after the effective date of coverage which result from a preexisting condition. Preexisting conditions are defined as those conditions for which medical advice or treatment was received or recommended no more than twelve months before the effective date of a person's coverage. However, whenever a covered person moves from one insured group to another, the insurer of the group to which the covered person moves shall give credit for the satisfaction of the preexisting condition period or portion thereof already served under the prior plan if the coverage is selected when the person first becomes eligible and the coverage is continuous to a date not more than thirty days prior to the effective date of the new coverage. Service under a probationary waiting period required by the employer is not considered to interrupt continuous service. The requirements with respect to limitations on preexisting condition exclusions for group health insurance coverage are described in Section 38-71-850.

(5) Except as provided in item (1)(b)(vii) of this section, the premium for the policy must be paid by the policyholder from the policyholder's funds or from funds contributed by the insured persons, or from both.

(6) A group policy or subscriber contract of accident and health insurance which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare must equal, and may exceed, the minimum standards for Medicare supplement policies as contained in regulations promulgated by the department.

SECTION 38-71-735. Required provisions.

No policy of group accident, group health, or group accident and health insurance may be delivered in this State unless it contains in substance the following provisions, or provisions which in the opinion of the director or his designee are more favorable to the persons insured, or at least as favorable to the persons insured, and more favorable to the policyholder. However, (1) items (f) and (k) do not apply to policies issued to a creditor; (2) the standard provisions required for individual policies do not apply to group policies; and (3) if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director or his designee, shall omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in a manner as to make the provision contained in the policy consistent with the coverage provided by the policy:

(a) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy continues in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro ratio premium for the time the policy was in force during the grace period.

(b) A provision that the validity of the policy may not be contested after it has been in force for two years from its date of issue and that no statement, except fraudulent misstatements, made by any person covered under the policy relating to insurability may be used in contesting the validity of the insurance with

respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during the person's lifetime nor unless it is contained in a written instrument signed by the person making the statement. The provision does not preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy.

(c) A provision that a copy of the application, if any, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured are considered representations and not warranties, and that no statement made by any person insured may be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

(d) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

(e) If the premiums or benefits vary by age, there must be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated. The provision must contain a clear statement of the method of adjustment to be used.

(f) A provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.

(g) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within the time does not invalidate nor reduce any claim if it can be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible.

(h) A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of fifteen days after the insurer received notice of any claim under the policy, the person making the claim is considered to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

(i) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at intervals the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within ninety days after the date of the loss. Failure to furnish proof within the time does not invalidate nor reduce any claim if it was not reasonably possible to furnish the proof within that time so long as the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

(j) A provision that all benefits payable under the policy other than benefits for loss of time will be paid not more than sixty days after receipt of proof of the loss. Subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of liability will be paid as soon as possible after receipt of the proof.

(k) A provision that benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured. If the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of law of this State if no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy also may provide that if any benefit is payable to the estate of a person or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay the benefit, up to an amount not

exceeding five thousand dollars, to any relative by blood or connection by marriage of the person who is considered by the insurer to be equitably entitled to the benefit.

(l) A provision that the insurer at its own expense may examine the person of the individual for whom claim is made as often as reasonably necessary while a claim is pending and in cases of death of the insured the insurer at its own expense also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in this State.

(m) A provision that no action at law or in equity may be brought to recover on the policy before the expiration of sixty days after written proof of loss has been filed in accordance with the requirements of the policy and that no such action may be brought at all unless brought within six years after the time written proof of loss is required to be furnished.

(n) In the case of a policy issued to a creditor, a provision that the insurer will furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable first must be applied to reduce or extinguish the indebtedness.

SECTION 38-71-737. Requirement of coverage for psychiatric conditions in group health insurance policies; “psychiatric conditions” defined.

(A) An offer to sell a group health insurance policy must include an offer of an optional rider or endorsement to provide benefits for psychiatric conditions as defined in this section. The offer of coverage may contain provisions prescribing different benefits for psychiatric conditions and physical conditions with respect to any deductible amount, coinsurance provision, or contract term affecting benefit determinations based upon use or nonuse of preferred providers.

(B) The offer of an optional rider or endorsement for a group health insurance policy must provide minimum benefits for psychiatric conditions not less than two thousand dollars for each member for each benefit year with a lifetime maximum benefit of ten thousand dollars. In the case of group health insurance coverage, as defined in Section 38-71-840, the requirements of Section 38-71-880 regarding parity in the application of certain limits to mental health benefits shall apply to those benefits defined as mental health benefits in Section 38-71-880(E). However, if group health insurance coverage is exempted from the requirements of Section 38-71-880, then the requirements of this provision shall apply. In addition, for group health insurance coverage, the requirements of this provision shall apply to benefits for psychiatric conditions which are not considered mental health benefits.

(C) This section does not prohibit an insurer from issuing or continuing to issue a health insurance policy which provides benefits greater than the minimum benefits required by this section or benefits generally more favorable to the insured than those required by this section.

(D) As used in this section, “psychiatric conditions” means those mental and nervous conditions, drug and substance addiction or abuse, alcoholism, or other conditions that are defined, described, or classified as psychiatric disorders or conditions in the most current publication of the American Psychiatric Association entitled “The Diagnostic and Statistical Manual of Mental Disorders”.

SECTION 38-71-740. Restrictions on mass-marketed insurance.

No mass-marketed accident, health, or accident and health insurance may be effected on a person in this State if the charges to the individual insureds are unreasonable in relation to the benefits provided. “Mass-marketed accident, health, or accident and health insurance” for purposes of this chapter means coverage under any group or blanket policy which is offered by means of direct response solicitation whether through a sponsoring organization or the mails or other media, except that it does not include coverage offered to an employee or union member through his employer or union, to a member of a professional association, to a member of a national association of retired or aged persons through the association, or to a member of a national association of war veterans either chartered by Congress or composed of veterans of a particular ethnic, racial, or religious background through the association. This coverage offered through a trust formed by one or more employers, labor unions, or both, or by a

professional association or association of retired or aged persons or war veterans to provide insurance coverage for employees, union members, and their dependents, or for association members and their dependents, is considered to be offered through the employer, union, or association respectively. "Direct response solicitation" means any offer by an insurer to persons in this State to effect such insurance coverage which enables the individual to apply or enroll for the insurance on the basis of that offer.

SECTION 38-71-750. Requirements of group policies extended to group policies issued outside State to residents; approval required for mass-marketed policies and certificates.

(1) No group accident, group health, or group accident and health insurance coverage may be extended to residents of this State under a policy issued outside this State which does not provide in substance the provisions of this article unless the director or his designee determines that certain provisions are not appropriate for the coverage provided.

(2) Any insurer extending blanket or group accident, health, or accident and health insurance under a policy issued outside this State to residents of this State shall comply with the requirements of this State relating to advertising and to claims settlement practices with respect to the insurance.

(3) Upon request of the director or his designee, copies of policies and certificates under a policy of group accident, group health, or group accident and health insurance issued outside this State and covering residents of this State must be made available on an informational basis only. However, mass-marketed accident, health, or accident and health insurance policies and certificates must receive approval of the director or his designee pursuant to Section 38-71-720 before they can be offered for sale to residents of this State.

SECTION 38-71-760. Standards for group accident and health insurance coverage, discontinuance, and replacement.

(a) This section applies to a group accident, group health, or group accident and health insurance or health maintenance organization policy or certificate that is delivered, issued for delivery, or renewed in this State which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis. It specifically includes a certificate issued under a policy that was issued to a trust located out of the State but which includes participating units located in the State. Renewal of these policies or certificates is presumed to occur on the anniversary date of the date that coverage was first effective unless another renewal date is specifically stated in the certificate.

(b) If a policy or contract subject to this article provides for automatic discontinuance of the policy or contract after a premium or subscription charge has remained unpaid through the grace period allowed for the payment, the carrier is liable for valid claims for covered losses incurred prior to the end of the grace period.

(c) If the actions of the carrier after the end of the grace period indicate that it considers the policy or contract as continuing in force beyond the end of the grace period such as by continuing to recognize claims subsequently incurred, the carrier is liable for valid claims for losses beginning on or before the effective date of the written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance may not be prior to midnight at the end of the third scheduled work day after the date upon which the notice is delivered.

(d) In addition to the notice required under Section 38-71-870 or Section 38-71-675, any notice of discontinuance by the carrier shall include a request to the group policyholder or other entity involved to notify certificate holders covered under the policy or subscriber contract of the date when the group policy or contract will discontinue and advise that, unless otherwise provided in the policy or contract, the carrier is not liable for claims for losses incurred after such date. The notice also shall advise, when the plan involves certificate holder contributions, that, if the policyholder or other entity continues to collect

contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits for which the contributions are collected.

(e) The carrier shall prepare and furnish to the policyholder or other entity at the same time an appropriate sample notice form to be distributed to the certificate holders concerned indicating the effective date of the discontinuance and urge the certificate holders to refer to their certificates or contracts in order to determine what rights are available to them as a result of the discontinuance.

(f) Every group policy, contract, or certificate issued subject to this article or under which the level of benefits is modified or amended shall provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group policy, contract, or certificate as required by the following subsections.

(g) In the case of a group life plan which contains a disability benefit extension of any type such as premium waiver extension, extended death benefit in the event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy, contract or certificate does not operate to terminate the extension.

(h) In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the group policy, contract or certificate during a disability has no effect on benefits payable for that disability or confinement.

(i) In the case of hospital or medical expense coverages other than dental expense, a reasonable extension of benefits or accrued liability provision is required. The provision is considered reasonable if it provides an extension of at least twelve months under major medical and comprehensive medical type coverages and under other types of hospital or medical expense coverages provides either an extension of at least ninety days or an accrued liability for expenses incurred during a period of disability or during a period of at least ninety days starting with a specific event which occurred while coverage was in force such as an accident.

(j) Any applicable extension of benefits or accrued liability must be described in any policy, contract, or certificate involved. The benefits payable during any period of extension or accrued liability are subject to the policy's, contract's, or certificate's regular benefit limits such as benefits ceasing at exhaustion of a benefit period or of maximum benefits. For hospital or medical expense coverages, the benefit payments are limited to payments applicable to the disabling condition only. However, the carrier may not charge any premium during any period of extension.

(k) A replacement carrier is considered to be a succeeding carrier within the meaning of this section if the effective date of the coverage provided by it is sixty-two days or less after the date of termination of coverage of the prior carrier.

(l) This subsection applies to the prior carrier.

(1) The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.

(2) For health insurance coverage as defined in Section 38-71-840, in all situations except the prior carrier's withdrawal from the large group market, the small group market or both markets in this State, the liability of the prior carrier for extension of benefits terminates at the earliest of the following:

(A) The date the individual has full coverage for the disabling condition under a group health plan with similar benefits and that plan makes reasonable provision for continuity of care for the disabling condition.

(B) The date the individual is no longer totally disabled.

(C) The date the extension period required in subparagraph (i) expires.

(D) The date of exhaustion of a benefit period of the payment of maximum benefits as provided for in subparagraph (j).

(m) This subsection applies to all groups.

(1) Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to classes eligible and actively at work and nonconfinement rules must be covered by the succeeding carrier's plan of benefits. For health insurance coverage as defined in Section 38-71-840,

nonconfinement rules are not permitted and absence from work due to any health status-related factor must be treated as being actively at work.

(2) Each person not covered under the succeeding carrier's plan of benefits in accordance with item (1) of this subsection (m) nevertheless must be covered by the succeeding carrier in accordance with the following rules if the individual was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the individual is a member of the class of individuals eligible for coverage under the succeeding carrier's plan. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.

(A) The minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan reduced by any benefits payable by the prior plan.

(B) Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:

(i) The date the individual becomes eligible under the succeeding carrier's plan as described in item (1) of this subsection (m).

(ii) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage, such as at termination of employment or ceasing to be an eligible dependent, as the case may be.

(iii) In the case of an individual who was totally disabled, and in the case of a type of coverage for which subsections (f) through (j) of this section require an extension of benefits or accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by those subsections or, if the prior carrier's policy or contract is not subject to those subsections, would have been required of that carrier had its policy or contract been subject to those subsections at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

(3) For health insurance coverage as defined in Section 38-71-840, in the case of an individual who was totally disabled at the time the prior plan was discontinued and replaced by a group health plan with similar benefits, and in the case in which subsection (1) of this section requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier must be the applicable level of benefits of the succeeding carrier's plan. This benefit may be reduced by any benefits paid by the prior plan.

(4) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection (m) during the period of time this limitation applies under the new plan must be the lesser of:

(A) the benefits of the new plan determined without application of the preexisting conditions limitation; and

(B) the benefits of the prior plan.

(5) The succeeding carrier, in applying any deductibles, coinsurance amounts applicable to the out-of-pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit must apply for the same or overlapping benefit periods and must be given for expenses actually incurred and applied against the deductible provisions or to the out-of-pocket maximums of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to similar deductible or coinsurance provisions.

(6) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan are determined in accordance with all of the definitions, conditions, and covered expense provisions of

the prior plan rather than those of the succeeding plan. The benefit determination must be made as if coverage had not been replaced by the succeeding carrier.

SECTION 38-71-770. Mandatory continuation and conversion privileges.

A group policy issued for delivery or renewed in this State which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis must provide that an employee or member who has been insured continuously under the group policy for at least six months whose insurance under the group policy has been terminated for any reason other than nonpayment of the required contribution is entitled to continue coverage under the group policy for the fractional policy month remaining at termination plus six additional policy months. A group policy is considered to be a successor policy within the meaning of this section if the effective date of the coverage provided by it is sixty-two days or less after the date of termination of coverage of the prior carrier. The employee or member is not entitled to have his coverage continued if the employee or member was entitled under federal law to continuation of his coverage for a period of greater duration than provided by this section. Continuation of coverage is subject to the group policy or a successor policy remaining in force and the employee paying the entire group premium, including any portion usually paid by the former employer, before the date each month that the group policy month begins. Policies which provide benefits for other than hospital, surgical, major medical, or which provide benefits for specific diseases or accidental injuries only are not affected by this section.

A notification of the privilege to continue coverage after termination must be included in each certificate of coverage. In addition, the employer shall clearly and meaningfully advise an employee upon termination of the right to continue insurance and shall advise the employee of the amount of premium required and of the employee's responsibility to pay the premium each month before the date that the policy month begins. An employee is not entitled to continue coverage under the group if eligible for other group coverage which provides similar benefits nor if the person is eligible for medicare benefits provided by Title XVIII of the United States Social Security Act or of any successor acts. Any benefits, except extended benefits payable by the policy during the period of continuation, are considered secondary to benefits under any other group health policy that is in force on a person insured through this continuation privilege.

SECTION 38-71-780. Required provision for continuation of coverage for handicapped and dependent children.

A group hospital or medical expense insurance policy, hospital service plan contract, or medical service plan contract delivered or issued for delivery in this State which provides that coverage of a dependent child of an employee or other member of the coverage group terminates upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age does not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (b) chiefly dependent upon the employee or member for support and maintenance, as long as proof of the incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

SECTION 38-71-790. Payment of benefits.

The benefits payable under any policy or contract of group accident, group health, and group accident and health insurance are payable to the employee or to some beneficiary or beneficiaries designated by him, other than the employer. However, if there is no designated beneficiary as to all or any part of the

insurance at the death of the employee or member, then the amount of insurance payable for which there is no designated beneficiary is payable to the estate of the employee or member, except that:

(1) The insurer may in such case, at its option, pay the insurance to any one or more of the following surviving relatives of the employee or member: wife, husband, mother, father, child or children, or brothers or sisters; and

(2) Payment of benefits for expenses incurred on account of hospitalization or medical or surgical aid, as provided in Section 38-71-800, may be made by the insurer to the hospital or other person furnishing the aid. Payment so made discharges the insurer's obligation with respect to the amount of insurance so paid.

SECTION 38-71-800. Hospital and medical expenses.

Any policy or contract of group accident, group health, or group accident and health insurance may include provisions for the payment by the insurer of benefits to the employee or other member of the insured group on account of hospitalization or medical or surgical aid for himself, his spouse, his child or children, or other individuals chiefly dependent upon him for support and maintenance.

SECTION 38-71-810. Readjustment of rates or refunds or dividends.

Any policy or contract of group accident, group health, or group accident and health insurance may provide for readjustment of the rate of premium based on experience thereunder at the end of the first year or of any subsequent year of insurance thereunder. The readjustment may be retroactive only for that policy year. Any refund under any plan for readjustment of the rate of premium based on the experience under group policies and any dividend paid under these policies may be used to reduce the policyholder's contribution to group insurance for the insureds of the policyholder and the excess over the contribution by the employer must be applied by the policyholder for the sole benefit of the insureds.

SUBARTICLE 2.

REQUIREMENTS FOR ISSUERS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

SECTION 38-71-840. Definitions.

(A) As used in this subarticle:

(1) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during the period, and no premium may be charged to the participant or beneficiary for any coverage during the period. The period begins on the enrollment date and runs concurrently with any waiting period under the plan.

(2) "Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) "Bona fide association" means, with respect to health insurance coverage offered in the State, an association which:

(a) has been actively in existence for at least five years;

(b) has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member;

- (e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
- (f) meets additional requirements as may be imposed under state law.
- (4) “COBRA continuation provision” means any of the following:
 - (a) Part 6, Subtitle B, Title I of the Employee Retirement Income Security Act of 1974 other than Section 609 of the act;
 - (b) Section 4908B of the Internal Revenue Code of 1986, other than subsection (f)(1) of the section insofar as it relates to pediatric vaccines; or
 - (c) Title XXII of the Public Health Service Act.
- (5) “Church plan” has the meaning given the term under Section 3(33) of the Employee Retirement Income Security Act of 1974.
- (6) “Director of Insurance” or “director” means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. “Director” also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by law in managing or supervising the Department of Insurance.
- (7) “Employee” has the meaning given the term under Section 3(6) of the Employee Retirement Income Security Act of 1974.
- (8) “Employer” has the meaning given the term under Section 3(5) of the Employee Retirement Income Security Act of 1974, except that the term includes only employers of two or more employees.
- (9) “Employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.
- (10) “Enrollment date” means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for the enrollment.
- (11) “Governmental plan” has the meaning given the term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any governmental plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the government.
- (12) “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered by a health insurance issuer in connection with the plan.
- (13) “Group health plan” means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care, including items and services paid for as medical care, to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.
- (14) “Health insurance coverage” means benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
 - (a) coverage only for accident, or disability income insurance, or any combination of accident and disability income insurance;
 - (b) coverage issued as a supplement to liability insurance;
 - (c) liability insurance, including general liability insurance and automobile liability insurance;
 - (d) workers’ compensation or similar insurance;
 - (e) automobile medical payment insurance;
 - (f) credit-only insurance;
 - (g) coverage for on-site medical clinics;
 - (h) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
 - (i) if offered separately:

- (i) limited scope dental or vision benefits;
- (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
- (iii) other similar, limited benefits as are specified in regulations;
- (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
- (k) if offered as a separate insurance policy:
 - (i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and
 - (iii) similar supplemental coverage under a group health plan.
- (15) “Group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage of number of eligible individuals or employees of an employer.
- (16) “Health insurance issuer” or “issuer” means any entity that provides health insurance coverage in this State. For purposes of this section, “issuer” includes an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.
- (17) “Health maintenance organization” means an organization as defined in Section 38-33-20(7).
- (18) “Health status-related factor” means any of the following factors in relation to the individual or a dependent of the individual: health status; medical condition, including both physical and mental illnesses; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; or disability.
- (19) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market but does not include short-term limited duration insurance.
- (20) “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the State elects to regulate coverage as coverage issued to small employers as defined in Section 38-71-1330.
- (21) “Large group market” means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by an employer that is not a small employer, as defined in Section 38-71-1330.
- (22) “Late enrollee” means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:
 - (a) the first period in which the individual is eligible to enroll under the plan if the initial enrollment period is a period of at least thirty days; or
 - (b) a special enrollment period under Section 38-71-850(E).
- (23) “Medical care” means amounts paid for:
 - (a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
 - (b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and
 - (c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).
- (24) “Network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(25) “Participant” has the meaning given the term under Section 3(7) of the Employee Retirement Income Security Act of 1974.

(26) “Placement” or being “placed” for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by the person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child’s placement with the person terminates upon the termination of such legal obligation.

(27) “Plan sponsor” has the meaning given the term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(28) “Preexisting condition exclusion” means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the date. Genetic information may not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the information.

(29) “Small group market” means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer, as defined in Section 38-71-1330.

(30) “Waiting period” means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

SECTION 38-71-850. Preexisting condition exclusion; limitations; creditable coverage; certification; enrollment for coverage.

(A) Subject to subsection (C), a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if the:

(1) exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) exclusion extends for not more than twelve months without medical care, treatment, or supplies ending after the effective date of coverage or twelve months after the enrollment date, whichever occurs first, or eighteen months after the enrollment date in the case of a late enrollee; and

(3) period of any preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage if any, as defined in item (B)(1), applicable to the participant or beneficiary as of the enrollment date.

(B)(1) For purposes of this subarticle, “creditable coverage” means, with respect to an individual, coverage of the individual under any of the following:

(a) a group health plan;

(b) health insurance coverage;

(c) Part A or Part B, Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55, Title 10 of the United States Code;

(f) a medical care program of the Indian Health Service or of a tribal organization;

(g) a state health benefits risk pool, including the South Carolina Health Insurance Pool;

(h) a health plan offered under Chapter 89 of Title 5, United States Code;

(i) a public health plan as defined in regulations;

(j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term does not include coverage consisting solely of those benefits excepted from the definition of health insurance coverage.

(2)(a) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(b) For purposes of item (2)(a) and item (C)(4), any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in Section 38-71-840, shall not be taken into account in determining the continuous period under subitem (a).

(3)(a) Except as otherwise provided under subitem (b), for purposes of applying subitem (A)(3), a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(b) A health insurance issuer offering group health insurance, may elect to apply item (A)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subitem (a). The election must be made on a uniform basis for all participants and beneficiaries. Under the election an issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(c) In the case of an election under subitem (b) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer:

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election; and

(ii) shall include in the statements a description of the effect of the election.

(4) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (D) or in such other manner as may be specified in regulations.

(C)(1) Subject to item (4), a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-one-day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to item (4), a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-one-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This item does not apply to coverage before the date of such adoption or placement for adoption.

(3) A health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Items (1) and (2) no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(D)(1)(a) A health insurance issuer offering group health insurance coverage, shall provide the certification described in subitem (b):

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision;

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(iii) on the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in subitem (a)(i) or (ii), whichever is later.

The certification under sub-subitem (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(b) The certification described in this subitem is a written certification of:

(i) the period of creditable coverage of the individual under the plan and the coverage, if any, under the COBRA continuation provision; and

(ii) the waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

(2) In the case of an election described in subitem (B)(3)(b) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under item (1):

(a) upon request of the plan or issuer, the issuer which issued the certification provided by the individual shall promptly disclose to the requesting plan or issuer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

(b) the issuer may charge the requesting plan or issuer for the reasonable cost of disclosing the information.

(3) The Director of Insurance shall establish rules to prevent an issuer's failure to provide information under item (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(E)(1) A health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage under such terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer, if applicable, required such a statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time.

(c) The employee's or dependent's coverage described in subitem (a):

(i) was under a COBRA continuation provision and the coverage under the provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or employer contributions toward the coverage were terminated;

(iii) was one of multiple health insurance plans offered by an employer and the employee elects a different plan during an open enrollment period.

(d) Under the terms of the plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subitem (c)(i) or termination of coverage or employer contribution described in subitem (c)(ii).

(2)(a) If:

(i) a group health plan makes coverage available with respect to a dependent of an individual;

(ii) the individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

(iii) a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption, the health insurance issuer offering health insurance coverage in connection with the group health plan shall provide for a dependent special enrollment period described in subitem (b) during which the person or, if not otherwise enrolled, the individual may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subitem must be not less than thirty-one days and begins on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption as the case may be described in subitem (a)(iii).

(c) If an individual seeks to enroll a dependent during the first thirty-one days of a dependent special enrollment period, the coverage of the dependent shall become effective:

- (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
 - (ii) in the case of a dependent's birth or a dependent's adoption or placement for adoption within thirty-one days of birth, as of the date of the birth; or
 - (iii) in the case of a dependent's adoption or placement for adoption beyond thirty-one days from the date of birth, the date of the adoption or placement for adoption.
- (3) A health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit a dependent, spouse, or minor or dependent child, of an employee, if the dependent is eligible, but not enrolled for coverage, to enroll for coverage under the terms of the plan if a court has ordered that coverage be provided for the dependent under a covered employee's health insurance plan and a request for enrollment is made within thirty days after the issuance of the court order.
- (F)(1) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (A) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if:
- (a) the period is applied uniformly without regard to any health status-related factors; and
 - (b) the period does not exceed two months, or three months in the case of a late enrollee.
- (2) A health maintenance organization described in subitem (1) may use alternative methods from those described in item (1) to address adverse selection as approved by the Director of Insurance or his designee.
- (G)(1)(a)(i) Subject to subitem (a)(ii), no period before July 1, 1996, shall be taken into account in determining creditable coverage.
- (ii) The Director of Insurance shall provide for a process either by bulletin or by order whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have the coverage credited but for subitem (a)(i) may be given credit for creditable coverage for the periods through the presentation of documents or other means.
- (b)(i) Subject to subitems (b)(ii) and (iii), subsection (D) applies to events occurring after June 30, 1996.
- (ii) In no case is a certification required to be provided under subsection (D) before June 1, 1997.
- (iii) In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under subsection (D) unless an individual, with respect to whom the certification is otherwise required to be made, requests the certification in writing.
- (c) In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996:
- (i) the individual may present other credible evidence of the coverage in order to establish the period of creditable coverage; and
 - (ii) a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the issuer's crediting or not crediting the coverage if the issuer has sought to comply in good faith with the applicable requirements under this section.

SECTION 38-71-860. Health status-related factors in relation to individual enrollees and their dependents; restrictions on eligibility rules and premium charges.

(A)(1) Subject to item (2), a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- (a) health status;
- (b) medical condition, including both physical and mental illnesses;
- (c) claims experience;
- (d) receipt of health care;
- (e) medical history;

(f) genetic information;

(g) evidence of insurability, including conditions arising out of acts of domestic violence;

(h) disability.

(2) To the extent consistent with Sections 38-71-850 and 38-71-1360 and any other applicable state law, item (1) shall not be construed:

(a) to require group health insurance coverage to provide particular benefits other than those provided under the terms of such coverage; or

(b) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) For purposes of item (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for the enrollment.

(B)(1) A health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) To the extent consistent with Sections 38-71-940, 38-71-200, and 38-55-50 and any other applicable state law, nothing in item (1) shall be construed to:

(a) restrict the amount that an employer may be charged for coverage under a group health plan under applicable state law; or

(b) prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention, in accordance with applicable state law.

SECTION 38-71-870. Coverage in small or large group market in connection with group health plan; nonrenewal or discontinuance; restrictions; modification of coverage; plan sponsor.

(A) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage for all eligible employees and dependents at the option of the plan sponsor of the plan.

(B) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

(2) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage or, with respect to coverage of an insured individual, fraud, or intentional misrepresentation by the insured individual or the individual's representative. If the fraud or intentional misrepresentation is made by a person with respect to any person's prior health condition, the insurer has the right also to deny coverage to that person or to impose as a condition of continued coverage the exclusion of the condition misrepresented.

(3) The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules as permitted under Section 38-71-1360(A)(4) in the case of the small group market or pursuant to applicable state law in the large group market.

(4) The issuer is ceasing to offer coverage in such market in accordance with subsection (C) and applicable state law.

(5) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in

the service area of the issuer or in the area for which the issuer is authorized to do business and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under Section 38-71-1360(C)(1).

(6) In the case of health insurance coverage that is made available in the small or large group market only through one or more bona fide associations, the membership of an employer in the association, on the basis of which the coverage is provided, ceases but only if such coverage is terminated under this item uniformly without regard to any health status-related factor relating to any covered individual.

(C)(1) In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable state law in such market only if the issuer:

(a) provides notice to each plan sponsor provided coverage of this type in such market, and participants and beneficiaries covered under the coverage, of the discontinuation at least ninety days before to the date of the discontinuation of the coverage;

(b) offers to each plan sponsor provided coverage of this type in the market, the option to purchase all or, in the case of the large group market, any other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subitem (b), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(2)(a) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in this State, health insurance coverage may be discontinued by the issuer only in accordance with applicable state law and if:

(i) the issuer provides notice to the Director of Insurance and to each plan sponsor, and participants and beneficiaries covered under the coverage, of the discontinuation at least one hundred eighty days before the date of the discontinuation of the coverage; and

(ii) all health insurance coverage issued or delivered for issuance in the State in such market is discontinued and coverage under the health insurance coverage in the market is not renewed.

(b) In the case of a discontinuation under subitem (a) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market in this State during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(D) At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the:

(1) large group market; or

(2) small group market if, for coverage that is available in the market other than only through one or more bona fide associations, the modification is consistent with state law and effective on a uniform basis among group health plans with that product.

(E) In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to “plan sponsor” is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

SECTION 38-71-880. Medical and surgical benefits and mental health benefits coverage; aggregate lifetime limits; application to small employers; applicability of section.

(A)(1) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health benefits:

(a) if the coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the coverage may not impose any aggregate lifetime limit on mental health benefits;

(b) if the coverage includes an aggregate lifetime limit, also referred to in this item as the “applicable lifetime limit”, on substantially all medical and surgical benefits, the coverage shall either:

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of the limit between the medical and surgical benefits and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Director of Insurance shall promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to the categories.

(2) In the case of health insurance coverage offered in connection with a group health plan that provides both medical and surgical benefits and mental health benefits:

(a) if the coverage does not include an annual limit on substantially all medical and surgical benefits, the coverage may not impose any annual limit on mental health benefits;

(b) if the coverage includes an annual limit on substantially all medical and surgical benefits, referred to as the “applicable annual limit”, the coverage shall either:

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(c) In the case of coverage that is not described in subitem (a) or (b) and that includes no or different annual limits on different categories of medical and surgical benefits, the Director of Insurance shall promulgate regulations under which subitem (b) is applied to the coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to the categories.

(B) To the extent consistent with Section 38-71-737 and any other applicable state law, nothing in this section shall be construed:

(1) as requiring health insurance coverage offered in connection with a group health plan to provide any mental health benefits; or

(2) in the case of such coverage that provides such mental health benefits, as affecting the terms and conditions, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity, relating to the amount, duration, or scope of mental health benefits under the coverage, except as specifically provided in subsection (A) in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

(C)(1)(a) This section shall not apply to any group health insurance coverage offered in connection with a group health plan for any plan year of a small employer.

(b) For purposes of subitem (a), “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(c) For purposes of this item:

(i) All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

(ii) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) Any reference in this item to an employer shall include a reference to any predecessor of the employer.

(2) This section shall not apply with respect to health insurance coverage offered in connection with a group health plan if the application of this section to such coverage results in an increase in the cost for such coverage of at least one percent.

(D) In the case of health insurance coverage offered in connection with a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, subsections (A) and (C)(2), shall be applied separately with respect to each such option.

(E) For purposes of this section:

(1) "Aggregate lifetime limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount that may be paid with respect to the benefits under the health insurance coverage with respect to an individual or other coverage unit.

(2) "Annual limit" means, with respect to benefits under health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to the benefits in a twelve-month period under the health insurance coverage with respect to an individual or other coverage unit.

(3) "Medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

(4) "Mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan, but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(F) This section does not apply to benefits for services furnished on or after December 31, 2006.

SUBARTICLE 3.

SMALL GROUP HEALTH INSURANCE

SECTION 38-71-910. Legislative intent.

The intent of this subarticle is to promote the availability of health insurance coverage to small employers, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules for continuity of coverage for employers and covered individuals, and to improve the efficiency and fairness of the small group health insurance marketplace.

SECTION 38-71-920. Definitions.

As used in this subarticle:

(1) "Small employer" means, in connection with a health insurance plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974 that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar year, employed no more than fifty eligible employees or employed an average of not more than fifty employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

(a) In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of state taxation, or that are treated as a single employer under subsections (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 must be considered one employer; and

(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year; and

(c) Any reference in the subarticle to an employer includes a reference to any predecessor of the employer.

(2) "Insurer" means any person who provides health insurance in this State. For the purposes of this subarticle, insurer includes a licensed insurance company, a health maintenance organization, a multiple

employer welfare arrangement, or any other person providing a plan of health insurance subject to state insurance regulation.

(3) "Health insurance plan" or "plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract, or health maintenance organization subscriber contract which provides benefits consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including items and services paid for medical care. It includes the entire contract between the insurer and the insured, including the policy, riders, endorsements, and the application, if attached. "Health insurance plan" does not include: accident-only; blanket accident and sickness; specified disease or hospital indemnity or other fixed indemnity insurance if offered as independent noncoordinated benefits; credit; limited scope dental or vision if offered separately; Medicare supplement if offered as a separate policy; long-term care if offered separately; disability-income insurance; coverage issued as a supplement to liability or other liability insurance, including general liability insurance and automobile liability insurance; coverage designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis; coverage for Medicare or Medicaid services pursuant to a contract with state or federal government; workers' compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or other similar coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(4) "Small employer insurer" means an insurer which offers health insurance plans covering the employees of a small employer.

(5) "Case characteristics" means the following characteristics of a small employer, as determined by a small employer insurer, which are considered by the insurer in the determination of premium rates for the small employer: age, gender, geographic area, industry, group size, and family composition. Geographic areas smaller than a county may not be used without prior approval of the director or his designee. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this subarticle. The adjustment for case characteristics must be objective and meet sound actuarial practices.

(6) "Director" means the person who is appointed by the Governor upon the advice and consent of the Senate and who is responsible for the operation and management of the Department of Insurance, including all of its divisions. The director may appoint or designate the person or persons who shall serve at the pleasure of the director to carry out the objectives or duties of the department as provided by law. "Director" also includes a designee or deputy director upon whom the director has bestowed any duty or function required of the director by law in managing or supervising the Department of Insurance.

(7) "Department" means the Department of Insurance.

(8) "New business premium rate" means, for each class of business as to a rating period, the lowest premium charged or offered, or which could have been charged or offered, by the small employer insurer to small employers with similar case characteristics for newly issued health insurance plans with the same or similar coverage.

(9) "Class of business" means all or a distinct grouping of small employers as shown on the records of the small employer insurer.

(a) A distinct grouping may be established only by the small employer insurer on the basis that the applicable health insurance plans:

- (i) are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer;
- (ii) have been acquired from another small employer insurer as a distinct grouping of plans;
- (iii) are provided through an association with membership of not less than fifty small employers which have been formed for purposes other than obtaining insurance; or
- (iv) are provided through a common group formed solely for the purpose of obtaining insurance as permitted by Section 38-71-730(1)(b).

(b) A small employer insurer may establish no more than two additional groupings on the basis of criteria, except group size, which are expected to produce substantial variation in administrative and marketing costs.

(c) The director or his designee may approve the establishment of additional distinct groupings upon application to the director or his designee and a finding by the director or his designee that action would enhance the efficiency and fairness of the small employer insurance marketplace.

(10) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director or his designee that a small employer insurer is in compliance with the provisions of Section 38-71-940 and that the rating methods used in establishing premium rates for applicable health insurance plans are objective and based on sound actuarial practices. This statement must be based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the insurer in establishing premium rates for applicable health insurance plans.

(11) "Rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect as determined by the small employer insurer.

(12) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer insurer to small employers with similar case characteristics for health insurance plans with the same or similar coverage.

(13) "Index rate" means, for each class of business for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(14) "Restricted network provision" means any provision of a health insurance plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the insurer pursuant to the laws and regulations of the State to provide health care services to covered individuals.

SECTION 38-71-930. Application of this subarticle.

(A) Except as provided in subsection (B), the provisions of this subarticle apply to any health insurance plan which provides coverage to one or more employees of a small employer.

(B) The provisions of this subarticle do not apply to individual health insurance policies which are subject to policy form and premium rate approval as may be provided in Title 38.

SECTION 38-71-940. Premium rates for health insurance plans; rating factors; involuntary business class transfer prohibited.

(A) Premium rates for health insurance plans subject to this subarticle are subject to the following requirements:

(1) The index rate for a rating period for a class of business may not exceed the index rate for any other class of business by more than twenty percent.

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to these employers under the rating system for that class of business, may not vary from the index rate by more than twenty-five percent of the index rate.

(3) The percentage increase in the renewal premium rate charged to a small employer for a new rating period may not exceed the sum of:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate. However, in the case of health insurance plans issued prior to the effective date of this section, if the change in the new business premium rate used to determine the maximum percentage

increase in the premium rate is less than zero percent, then zero percent may be used as the percentage change in the new business premium rate during the first twelve-month period from the effective date of this section.

(b) an adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the insurer's rate manual for the class of business.

(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the insurer's rate manual for the class of business.

(4) A health insurance plan that contains a restricted network provision shall not be considered similar coverage to a health insurance plan that does not contain such a provision, provided that the restriction of benefits to network providers results in substantial differences in claim costs.

(5) If group size is used as a case characteristic by a small employer insurer, the highest rate factor associated with a group size classification may not exceed the lowest rate factor associated with such a classification by more than twenty percent.

(B) Nothing in this section is intended to affect the use by a small employer insurer of legitimate rating factors other than claim experience, health status, or duration of coverage in the determination of premium rates. Small employer insurers shall apply rating factors, including case characteristics, consistently with respect to all small employers within a class of business.

(C) Unless the small employer no longer meets the criteria established for its existing class of business:

(1) a small employer insurer may not transfer involuntarily a small employer into or out of a class of business; and

(2) a small employer insurer may not offer to transfer a small employer into or out of a class of business, unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration since issue.

SECTION 38-71-960. Required disclosure in solicitation and sales materials; proprietary or trade secret information.

In connection with offering any health insurance plans to small employers, each small employer insurer shall make reasonable disclosure in solicitation and sales materials provided to small employers of:

(1) the extent to which premium rates for a specific small employer are established or adjusted due to case characteristics, family composition, class of business, and the claim experience, health status, or duration of coverage of the employees or dependents of the small employer;

(2) the provisions concerning the insurer's right to change premium rates and the factors, including case characteristics, which affect changes in premium rates;

(3) a description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;

(4) the provisions relating to renewability of coverage;

(5) the provisions relating to any preexisting condition exclusion; and

(6) the benefits and premiums available under all health insurance plans for which the employer is qualified.

Information under this section must be provided to small employers in a manner determined to be understandable by the average small employer and must be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

An insurer is not required under this section to disclose any information that is proprietary or trade secret information under applicable law.

SECTION 38-71-970. Insurer rating and renewal records; filing of certification; confidentiality.

(A) A small employer insurer shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and

documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(B) Each small employer insurer shall file each March first with the department an actuarial certification certifying that the insurer is in compliance with this section and that the rating methods of the insurer are actuarially sound. A copy of the certification must be retained by the insurer at its principal place of business.

(C) A small employer insurer shall make the information and documentation described in subsection (A) available to the director or his designee upon request. The information must be considered proprietary and trade secret information and is not subject to disclosure by the director or his designee to persons outside of the department except as agreed to by the insurer or as ordered by a court of competent jurisdiction.

SECTION 38-71-980. Suspension of premium rate restrictions upon request of certain insurers.

The director or his designee may suspend all or any part of Section 38-71-940 as to the premium rates applicable to one or more small employers for one or more rating periods upon a filing by the small employer insurer and a finding by the director or his designee that either the suspension is reasonable in light of the financial condition of the insurer or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

SECTION 38-71-990. Effective date of this subarticle.

The provisions of this subarticle apply to each health insurance plan for a small employer that is delivered, issued for delivery, renewed, or continued in this State after the effective date of this subarticle. For purposes of this section, the date a plan is continued is the first rating period which commences after the effective date of this subarticle.

ARTICLE 9.

BLANKET ACCIDENT AND HEALTH INSURANCE

SECTION 38-71-1010. “Blanket accident and health insurance” defined.

“Blanket accident and health insurance” is defined to be that form of accident and health insurance covering special groups of individuals as enumerated in one of the following items:

- (1) under a policy or contract issued to any common carrier, which must be considered the policyholder, covering a group defined as all individuals who may become passengers on the common carrier;
- (2) under a policy or contract issued to an employer, who must be considered the policyholder, covering any group of employees defined by reference to exceptional hazards incident to the employment;
- (3) under a policy or contract issued to an employer, who is considered the policyholder, covering employees or independent contractors, or both, under contract to the employer while traveling to and from and while attending meetings at a common location as a group or in groups incident to their employment or contractual arrangement;
- (4) under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, which or who must be considered the policyholder, covering students or teachers;
- (5) under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, which must be considered the policyholder, covering all of the members of the department or group;
- (6) under a policy or contract issued to any other similar group which, in the discretion of the director or his designee, may be eligible for issuance of a blanket accident and health policy or contract either under special circumstances, exceptional hazards, or for short periods of duration.

SECTION 38-71-1020. Requirements as to policies.

All blanket accident and health insurance policies are subject to the provisions of Articles 1 and 3 of this chapter. However, no policy is required to contain any of the required policy provisions set forth in Section 38-71-340. However, no policy may contain any provision relative to notice of claim, proofs of loss or time of payment of claims, or the time within which suit may be brought upon the policy which, in the opinion of the director or his designee, is less favorable to the insured than would be permitted by the required policy provisions.

SECTION 38-71-1030. Individual applications and certificates not required.

An individual application is not required from an individual covered under a blanket accident and health policy or contract, nor is it necessary for the insurer to furnish each individual a certificate.

SECTION 38-71-1040. Payment of benefits.

All benefits under any blanket accident and health policy are payable to the individual insured, to his designated beneficiary or beneficiaries, or to his estate, except that if the individual insured is a minor, the benefits may be made payable to his parent, guardian, or other person actually supporting him.

SECTION 38-71-1050. Legal liability of policyholders not affected.

Nothing contained in this article affects the legal liability of policyholders for the death of, or injury to, any member of the group.

ARTICLE 11.

FRANCHISE ACCIDENT AND HEALTH INSURANCE

SECTION 38-71-1110. “Franchise accident and health insurance” defined.

“Accident and health insurance on a franchise plan” is that form of accident and health insurance issued to (1) three or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency, or department or (2) ten or more members of any trade or professional association, labor union, or any other association having had an active existence for at least two years when the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance, when (a) the insureds, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by the insureds and (b) the employer, union, or association has approved and endorsed the policy being sold to its employees or members. Accident and health insurance on a franchise plan may be written under rates less than the usual rates for the insurance, but all premium rates and discounts the insurer proposes to use must be filed with the department and approved by the director or his designee as required by Section 38-71-310.

ARTICLE 13.

SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

SECTION 38-71-1310. Short title.

This article shall be known and may be cited as the “Small Employer Health Insurance Availability Act”.

SECTION 38-71-1320. Purpose and intent.

The purpose and intent of this article is to promote the availability of health insurance coverage to small employers, excluding individual health insurance plans, regardless of their health status or claims experience, to provide for development of “basic” and “standard” health insurance plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

SECTION 38-71-1330. Definitions.

As used in this article:

- (1) “Basic health insurance plan” means a lower cost health insurance plan developed pursuant to Section 38-71-1420.
- (2) “Board” means the board of directors of the program established pursuant to Section 38-71-1410.
- (3) “Commissioner” means the Chief Insurance Commissioner of this State.
- (4) “Committee” means the advisory committee to the commissioner referred to in Section 38-71-1420.
- (5) “Dependent” means a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student between the ages of nineteen and twenty-two and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.
- (6) “Eligible employee” means an employee as defined in Section 38-71-710(1) or Section 38-71-840 who works on a full-time basis and has a normal work week of thirty or more hours.
- (7) “Employer contribution rule” means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.
- (8) “Group participation rule” means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.
- (9) “Health insurance plan” or “plan” means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract, or health maintenance organization subscriber contract which provides benefits consisting of medical care provided directly through insurance or reimbursement, or otherwise and including items and services paid for medical care. It includes the entire contract between the insurer and the insured, including the policy, riders, endorsements, and the application, if attached. “Health insurance plan” does not include: accident-only; blanket accident and sickness; specified disease or hospital indemnity or other fixed indemnity insurance if offered as independent noncoordinated benefits; credit; limited scope dental or vision if offered separately; Medicare supplement if offered as a separate policy; long-term care if offered separately; disability income insurance; coverage issued as a supplement to liability or other liability insurance, including general liability insurance and automobile liability insurance; coverage designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis; coverage for Medicare or Medicaid services pursuant to a contract with state or federal government; workers’ compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or other similar coverage specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits.
- (10) “Insurer” means any entity that provides health insurance in this State. For the purposes of this article, insurer includes an insurance company, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation, including multiple employer self-insured health plans licensed pursuant to Section 38-41-10, et seq.
- (11) “Medical care” means amounts paid for:

- (a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;
- (b) amounts paid for transportation primarily for and essential to medical care referred to in subitem (a); and
- (c) amounts paid for insurance covering medical care referred to in subitems (a) and (b).
- (12) "Network plan" means a health insurance plan issued by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer.
- (13) "Plan of operation" means the plan of operation of the program established pursuant to Section 38-71-1410.
- (14) "Program" means the South Carolina Small Employer Insurer Reinsurance Program created by Section 38-71-1410.
- (15) "Reinsuring insurer" means a small employer insurer participating in the reinsurance program pursuant to Section 38-71-1410.
- (16) "Risk-assuming insurer" means a small employer insurer whose application is approved by the commissioner pursuant to Section 38-71-1390.
- (17) "Small employer" means, in connection with a health insurance plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or employer, as defined in Section 3(5) of the Employee Retirement Income Security Act of 1974, that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar year, employed no more than fifty eligible employees or employed an average of not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.
- (1) In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, or that are treated as a single employer under subsections (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be considered one employer; and
- (2) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year; and
- (3) Any reference in this article to an employer includes a reference to any predecessor of the employer.
- (18) "Small employer insurer" means an insurer that offers health insurance plans covering eligible employees of one or more small employers in this State.
- (19) "Standard health insurance plan" means a health insurance plan developed pursuant to Section 38-71-1420.

SECTION 38-71-1340. Application of article.

- (A) Except as provided in subsection (B), the provisions of this article apply to any health insurance plan which provides group coverage to groups of two to fifty.
- (B) The provisions of this article do not apply to individual health insurance policies which are subject to policy form and premium rate approval as may be provided in Title 38 of the 1976 Code.

SECTION 38-71-1350. Premium rates; requirements.

Premium rates for health insurance plans subject to this article are governed by the rating restrictions contained in Section 38-71-910, et seq. of the 1976 Code, as amended by 1994 Act No. 339.

Premium rates for health insurance plans shall comply with the requirements of this section notwithstanding any reinsurance premiums or assessments paid or payable by small employer insurers pursuant to Section 38-71-1410.

SECTION 38-71-1360. Insurers required to offer all plans actively marketed to small employers; availability to all eligible employees; network plans; denial of coverage.

(A)(1) Every small employer insurer shall, as a condition of transacting business in this State with small employers, actively offer to small employers all health insurance plans actively marketed to small employers in this State, including at least two health insurance plans. One health insurance plan offered by each small employer insurer must be a basic health insurance plan and one plan must be a standard health insurance plan.

(2) Coverage under such health insurance plan must be offered to every eligible employee of a small employer and his or her dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the health insurance plan and may not place any restriction which is inconsistent with Section 38-71-860 on an eligible employee being a participant or beneficiary. A small employer insurer may not offer coverage only to certain individuals in a small employer group, or to only part of the group, except as provided in Section 38-71-850 for late enrollees.

(3) Except with respect to applicable preexisting condition limitation periods or late enrollees as provided in Section 38-71-850, a small employer insurer shall not modify a health insurance plan with respect to a small employer or any eligible employee or dependent through rider, endorsement, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered under the plan.

(4)(a) Except as provided in Sections 38-71-1360(C) and (D), a small employer insurer shall issue these health insurance plans to any eligible small employer that applies for any such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health insurance plan relating to employer contribution rules and group participation rules and not inconsistent with this article.

(b) In the case of a small employer insurer that establishes more than one class of business pursuant to Section 38-71-920, the small employer insurer shall maintain and issue to eligible small employers these health insurance plans in addition to at least one basic health insurance plan and at least one standard health insurance plan in each class of business so established. A small employer insurer may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(i) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health insurance plan;

(ii) the criteria are not related to the health status or claim experience of the small employer;

(iii) the criteria are applied consistently to all small employers applying for coverage in the class of business; and

(iv) the small employer insurer provides for the acceptance of all eligible small employers into one or more classes of business.

The requirement to offer these health insurance plans to small employers shall not apply to a class of business into which the small employer insurer is no longer enrolling new small businesses.

(5) The provisions of this subsection (A) of this section shall be effective one hundred eighty days after the commissioner's approval of the basic health insurance plan and the standard health insurance plan developed pursuant to Section 38-71-1420; provided that if the Small Employer Insurer Reinsurance Program created pursuant to Section 38-71-1410 is not yet operative on that date, the provisions of this paragraph shall be effective on the date that the program begins operation.

(B)(1) After the commissioner's approval of the basic health insurance plan and the standard health insurance plan developed pursuant to Section 38-71-1420, a small employer insurer shall file with the commissioner, in the form and manner prescribed by the commissioner, the basic and standard health insurance plans to be used by the insurer. The insurer shall certify to the commissioner that the plans as filed are in substantial compliance with the provisions as approved by the commissioner. Upon the commissioner's receipt of the certification, the insurer may use the certified plans unless their use is disapproved by the commissioner.

(2) The commissioner may, at any time, after providing notice and an opportunity for hearing, disapprove the continued use by a small employer insurer of a basic or standard health insurance plan on the grounds that the plan does not meet the requirements of this article.

(C)(1) In the case of a small employer insurer that offers health insurance coverage through a network plan, the small employer insurer may:

(a) limit the employers that may apply for such coverage to those with eligible employees who live, work, or reside in the service area for such network plan; and

(b) within the service area of any such plan, deny such coverage to such employers if such insurer has demonstrated to the satisfaction of the commissioner that:

(i) it will not have the capacity to deliver services adequately to members of any additional groups because of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this item uniformly to all employers without regard to claims experience of those employers and their employees and their dependents or any health status-related factors relating to such employees and dependents.

(2) A small employer insurer that offers health insurance coverage through a network plan that cannot offer coverage pursuant to item (1)(b) may not offer coverage in the applicable area to new cases of employer groups with more than fifty eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the insurer notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(D)(1) A small employer insurer may deny health insurance coverage to small employers for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (A) would place the small employer insurer in a financially impaired condition or if the small employer insurer has demonstrated to the commissioner that it:

(a) does not have the financial reserves necessary to underwrite additional coverage; and

(b) is applying this item uniformly to all small employers in the State without regard to claims experience of those employers and their employees and their dependents or any health status-related factor relating to such employees and dependents.

(2) A small employer insurer that denies coverage to a small employer pursuant to item (1) may not offer coverage in the State to new cases of employer groups with more than fifty eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the small employer insurer demonstrates to the commissioner that it has sufficient financial reserves to underwrite additional coverage. The commissioner may provide for the application of this subsection on a service-area-specific basis.

SECTION 38-71-1370. Applicability of certain code sections; late enrollees.

(A) Except to the extent inconsistent with specific provisions of this article, all provisions of Article 5, are applicable to any insurance plans required to be offered by small employer insurers.

(B) Late enrollees may be excluded from coverage for the greater of eighteen months or an eighteen month preexisting condition exclusion; however, if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed eighteen months.

SECTION 38-71-1380. Notification of intent to operate; certain reinsuring insurers not permitted to continue to reinsure health insurance plan.

(A)(1) Within sixty days after the plan of operation is approved by the commissioner under Section 38-71-1410, each small employer insurer shall notify the commissioner of the insurer's intention to operate as a risk-assuming insurer or a reinsuring insurer. A small employer insurer seeking to operate as a risk-assuming insurer shall make an application pursuant to Section 38-71-1390.

(2) The decision shall be binding for a five-year period except that the initial decision shall be binding for two years. The commissioner may permit an insurer to modify its decision at any time for good cause shown.

(3) The commissioner shall establish an application process for small employer insurers seeking to change their status under this subsection. In the case of a small employer insurer that has been acquired by another such insurer, the commissioner may waive or modify the time periods established in paragraph (2).

(B) A reinsuring insurer that applies and is approved to operate as a risk-assuming insurer shall not be permitted to continue to reinsure any health insurance plan with the program. Such an insurer shall pay a prorated assessment based upon business issued as a reinsuring insurer for any portion of the year that the business was reinsured.

SECTION 38-71-1390. Application to become risk-assuming insurer; approval or denial; factors to consider.

(A) Any small employer insurer may elect to become a risk-assuming insurer upon application to and approval by the commissioner. A small employer insurer shall not be approved as a risk-assuming insurer if the commissioner finds that the insurer is not capable of assuming that status pursuant to the criteria set forth in subsection (B) of this section. The insurer shall provide public notice of its application to become a risk-assuming insurer. A small employer insurer's application to be a risk-assuming insurer shall be approved unless disapproved by the commissioner within sixty days after the insurer's application. A small employer insurer that has had its application to be a risk-assuming insurer disapproved may request and shall be granted a public hearing within sixty days after the disapproval.

(B) In determining whether or not to approve an application by a small employer insurer to become a risk-assuming insurer, the commissioner shall consider the insurer's financial condition and the financial condition of its parent or guaranteeing corporation, if any; its history of assuming and managing risk; its ability to assume and manage the risk of enrolling small employers without the protection of the reinsurance provided in Section 38-71-1410; and its commitment to fairly market to all small employers.

SECTION 38-71-1400. Election to become reinsuring insurer.

(A) A small employer insurer may elect to become a reinsuring insurer and operate under the provisions of this section and Section 38-71-1410.

(B) Each reinsuring insurer shall conduct business with its members and subscribers, and administer claims for coverage reinsured by the program, in the same manner as it would administer health claims that it writes without reinsurance.

SECTION 38-71-1410. South Carolina Small Employer Insurer Reinsurance Program.

(A) There is hereby created a nonprofit entity to be known as the South Carolina Small Employer Insurer Reinsurance Program, which shall become operational on July 1, 1995.

(B)(1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of paragraph (2), the board shall consist of eight members appointed by the commissioner plus the commissioner or his designated representative, who shall serve as an ex officio member of the board.

(2) In selecting the members of the board, the commissioner shall include representatives of small employers and small employer insurers and such other individuals determined to be qualified by the commissioner. At least five members of the board shall be representatives of insurers, one of whom shall be a licensed independent insurance agent who represents multiple health and accident insurance carriers, and shall be selected from individuals nominated in this State pursuant to procedures and guidelines developed by the commissioner.

(3) The initial board members shall be appointed as follows: two of the members to serve a term of two years; three of the members to serve a term of four years; and three of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his successor is appointed.

(4) A vacancy in the board shall be filled by the commissioner. A board member may be removed by the commissioner for cause.

(C) Not later than September 1, 1994, each small employer insurer shall make a filing with the commissioner containing the insurer's net health insurance premium derived from health insurance plans delivered or issued for delivery to small employers in this State in the previous calendar year.

(D) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to assure the fair, reasonable, and equitable administration of the program, and to provide for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon written approval by the commissioner.

(E) If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the commissioner shall, after notice and hearing, adopt and promulgate a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(F) The plan of operation shall:

(1) establish procedures for handling and accounting of program assets and monies and for an annual fiscal reporting to the commissioner;

(2) establish procedures for selecting a licensed administrator, as provided in Sections 38-51-10 through 38-51-60, and setting forth the powers and duties of the licensed administrator;

(3) establish procedures for reinsuring risks in accordance with the provisions of this section;

(4) establish procedures for collecting assessments from reinsuring insurers to fund claims and administrative expenses incurred or estimated to be incurred by the program;

(5) establish a methodology for applying the dollar thresholds contained in this section in the case of insurers that pay or reimburse health care providers through capitation or salary; and

(6) provide for any additional matters necessary for the implementation and administration of the program.

(G) The program shall have the general powers and authority granted under the laws of this State to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health insurance plans directly to either groups or individuals. In addition, the program shall have the specific authority to:

(1) enter into contracts as are necessary or proper to carry out the provisions and purposes of this article, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring insurers;

(3) take any legal action necessary to avoid the payment of improper claims against the program;

(4) define the health insurance plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this article;

(5) establish rules, conditions, and procedures for reinsuring risks under the program;

(6) establish actuarial functions as appropriate for the operation of the program;

(7) assess reinsuring insurers in accordance with the provisions of subsection (K), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(8) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(9) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for insurers and may be carried as admitted assets;

(H) A reinsuring insurer may reinsure with the program as provided for in this subsection:

(1) with respect to any health insurance plan offered by the small employer insurer to small employers, the program shall reinsure the level of coverage as defined in the plan of operation;

(2) a small employer insurer may reinsure an entire employer group within sixty days of the commencement of the group's coverage under a health insurance plan;

(3) a reinsuring insurer may reinsure an eligible employee or dependent within a period of sixty days following the commencement of the coverage with the small employer. A newly-eligible employee or dependent of the reinsured small employer may be reinsured within sixty days of the commencement of his coverage;

(4)(a) the program shall not reimburse a reinsuring insurer with respect to the claims of a reinsured employee or dependent until the insurer has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the reinsuring insurer shall be responsible for ten percent of the next fifty thousand dollars of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring insurers' liability under this subparagraph shall not exceed a maximum limit of ten thousand dollars in any one calendar year with respect to any reinsured individual;

(b) the board annually may adjust the initial level of claims, the coinsurance percentage, and the maximum limit to be retained by the insurer with the approval of the commissioner.

(5) a small employer insurer may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health insurance plan;

(6) a reinsuring insurer shall apply all managed care and claims handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(I)(1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must contain a provision surcharging the reinsurance premium rate of a small employer insurer which does not employ effective cost containment and managed care arrangements including, but not limited to:

(a) preferred provider organizations;

(b) utilization review;

(c) case management;

(d) other.

The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer insurers in the State. The methodology shall provide for the development of base reinsurance premium rates which shall be multiplied by the factors set forth in paragraph (2) to determine the premium rates for the program. The base reinsurance premium rates shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer insurers for health insurance plans with benefits similar to the standard health insurance plan.

(2) Premiums for the program shall be as follows:

(a) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this paragraph.

(b) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this paragraph.

(3) The board periodically shall review the methodology established under paragraph (1), including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience

of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner.

(J) If a health insurance plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in Section 38-71-910, et seq. of the 1976 Code.

(K)(1) Before March first of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring insurers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring insurers. The assessment formula shall be based on:

(i) each reinsuring insurer's share of the total premiums earned in the preceding calendar year from health insurance plans delivered or issued for delivery to small employers in this State by reinsuring insurers; and

(ii) each reinsuring insurer's share of the premiums earned in the preceding calendar year from newly-issued health insurance plans delivered or issued for delivery during the calendar year to small employers in this State by reinsuring insurers.

(b) The formula established pursuant to subparagraph (a) shall not result in any reinsuring insurer having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the reinsuring insurer's total premiums earned in the preceding calendar year from health insurance plans delivered or issued for delivery to small employers in this State by reinsuring insurers to the total premiums earned in the preceding calendar year from health insurance plans delivered or issued for delivery to small employers in this State by all reinsuring insurers.

(c) The board may, with approval of the commissioner, change the assessment formula established pursuant to subparagraph (a) from time to time as appropriate. The board may provide for the shares of the assessment base attributable to total premium and to the previous year's premium to vary during a transition period.

(d) Subject to the approval of the commissioner, the board shall make an adjustment to the assessment formula for reinsuring insurers that are approved health maintenance organizations which are federally qualified under 42 U.S.C. Sec. 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer insurers.

(3)(a) Before March first of each year, the board shall determine and file with the commissioner an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph (c), the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the commissioner within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments and consideration of the administrative costs of the program, the appropriateness of the premiums charged, the level of insurer retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the commissioner within ninety days following the end of the applicable calendar year, the commissioner may evaluate the operations of the program and implement such amendments to the plan of operation the commissioner considers necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this subparagraph is five percent of total premiums earned in the previous calendar year from health insurance plans delivered or issued for delivery to small employers in this State by reinsuring insurers.

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

(5) Each reinsuring insurer's proportion of the assessment shall be determined annually by the board based on annual statements and other reports considered necessary by the board and filed by the reinsuring insurers with the board.

(6) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(7) A reinsuring insurer may seek from the commissioner a deferment from all or part of an assessment imposed by the board. The commissioner may defer all or part of the assessment of a reinsuring insurer if the commissioner determines that the payment of the assessment would place the reinsuring insurer in a financially impaired condition. If all or part of an assessment against a reinsuring insurer is deferred, the amount deferred shall be assessed against the other participating insurers in a manner consistent with the basis for assessment set forth in this subsection. The reinsuring insurer receiving the deferment shall remain liable to the program for the amount deferred and shall be prohibited from reinsuring any individuals or groups with the program until such time as it pays the assessments.

(L) Neither the participation in the program as reinsuring insurers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this article shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring insurers either jointly or separately.

(M) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation, if any, to be paid to agents for the sale of basic and standard health insurance plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide on-going service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(N) The program shall be exempt from any and all taxes.

SECTION 38-71-1420. Advisory committee.

(A) The Governor shall appoint an advisory committee to the commissioner which shall recommend the form and level of coverages to be made available by small employer insurers pursuant to Section 38-71-1360. At least one member of the committee shall be a licensed independent insurance agent who represents multiple health and accident insurance carriers. In preparing its initial recommendations, the advisory committee shall build on the work of the Governor's Committee on Basic Health Services.

(B) The committee shall recommend benefit levels, cost-sharing levels, exclusions and limitations for the basic health insurance plan and the standard health insurance plan. The committee shall specifically recommend which, if any, mandated coverages of health care services or health care providers should be included in the basic and standard health insurance plans and shall recommend as well whether the plans should be exempt from any other statutory provisions otherwise applicable to group health insurance policies. Section 38-71-200 is applicable to the basic and standard health insurance plans and is not subject to exemption. The committee also shall design a basic health insurance plan and a standard health insurance plan which contain benefit and cost-sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

(1) The plans recommended by the committee may include cost containment features such as:

(a) utilization review of health care services, including review of medical necessity of hospital and physician services;

(b) case management;

(c) selective contracting with hospitals, physicians, and other health care providers;

(d) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(e) other managed care provisions.

(2) The committee shall submit the health insurance plans described in paragraphs (A) and (B) to the commissioner for approval by January 1, 1995. If, for any reason, the committee does not provide the commissioner with a recommendation as to the form and level of coverages to be made available pursuant to this article, the board shall make such recommendation to the commissioner. If, subsequent to the approval of the benefit levels of the basic and standard health insurance plans, amendments to the plans become necessary, the board shall make such recommendations to the commissioner for his approval.

SECTION 38-71-1430. Annual public report.

The board, in consultation with members of the committee, shall study and make a public report each year to the commissioner on the effectiveness of this article. The report shall analyze the effectiveness of the act in promoting rate stability, product availability, and coverage affordability. The report shall include the total number of basic and standard policies sold in the State noting whether these insureds have ever been denied coverage before July 1, 1995. The report shall contain a detailed analysis of the financial condition of the reinsurance pool including losses and assessments by year. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance marketplace. The report shall address whether insurers and agents are fairly marketing or issuing health insurance plans to small employers in fulfillment of the purposes of this article. The report may contain recommendations for market conduct or other regulatory standards or action.

SECTION 38-71-1440. Requirements upon small employer insurers.

(A) Each small employer insurer shall fairly market health insurance plan coverage, including the basic and standard health insurance plans, to eligible small employers in the State. A small employer insurer shall not deny coverage to a small employer based solely on the employer's occupation.

(B)(1) Except as provided in paragraph (2), no small employer insurer or its agent shall, directly or indirectly, engage in the following activities:

(a) encouraging or directing small employers to refrain from filing an application for coverage with the small employer insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer;

(b) encouraging or directing small employers to seek coverage from another insurer because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(2) The provisions of paragraph (1) shall not apply with respect to information provided by a small employer insurer or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer insurer or health maintenance organization.

(C)(1) Except as provided in paragraph (2), no small employer insurer shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health insurance plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(D) A small employer insurer shall provide reasonable compensation, if provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health insurance plan.

(E) No small employer insurer may terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer insurer.

(F) No small employer insurer or agent may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(G) Denial by a small employer insurer of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(H) If a small employer insurer enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health insurance plans to small employers in this State, the third-party administrator shall be subject to this article as if it were a small employer insurer.

SECTION 38-71-1450. Promulgation of regulations.

The Director of Insurance may promulgate regulations as may be necessary or appropriate to carry out the provisions of this article.

ARTICLE 15.

ACCESS TO EMERGENCY MEDICAL CARE

SECTION 38-71-1510. Short title.

This article may be cited as the “Access to Emergency Medical Care Act”.

SECTION 38-71-1520. Definitions.

As used in this article:

(1) “Emergency medical care” means those health care services provided in a hospital emergency facility to evaluate and treat an emergency medical condition.

(2) “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(3) “Emergency medical provider” means hospitals licensed by the South Carolina Department of Health and Environmental Control, hospital-based services, and physicians licensed by the State Board of Medical Examiners who provide emergency medical care.

(4) “Managed care organization” means a licensed insurance company, a hospital or medical services plan contract, a health maintenance organization, or any other entity which is subject to regulation by the department and which operates a managed care plan.

(5) “Managed care plan” means a plan operated by a managed care organization which provides for the financing and delivery of health care and treatment services to individuals enrolled in the plan through its own employed health care providers or contracting with selected specific providers that conform to explicit selection standards, or both. A managed care plan also customarily has a formal organizational structure for continual quality assurance, a certified utilization review program, dispute resolution, and financial incentives for individual enrollees to use the plan’s participating providers and procedures.

SECTION 38-71-1530. Screening; initial intervention; role of managed care organization; payments to providers.

(A) A patient who presents to an emergency department, by the Federal Social Security Act, must be screened to determine whether an emergency medical condition exists. This evaluation may include, but

is not limited to, diagnostic testing to assess the extent of the condition, sickness, or injury and radiographic procedures and interpretation.

(B) Appropriate intervention must be initiated by medical personnel to stabilize any emergency medical condition before requesting authorization for the treatment by a managed care organization.

(C) A managed care organization shall inform its insureds, enrollees, patients, and affiliated providers about all policies related to emergency medical care access, coverage, payment, and grievance procedures. It is the ultimate responsibility of the managed care organization to inform any contracted third party administrator, independent contractor, or primary care provider about the emergency medical care provisions contained in this subsection.

(D) A managed care organization which includes emergency medical care services as part of its policy or contract shall provide coverage and shall subsequently pay providers for emergency medical care services provided to an insured, enrollee, or patient who presents an emergency medical condition. This subsection must not be construed to require coverage for illnesses, diseases, equipment, supplies, or procedures or treatments which are not otherwise covered under the terms of the insured's policy or contract.

(E) A managed care organization may not retrospectively deny or reduce payments to providers for emergency medical care of an insured, enrollee, or patient even if it is determined that the emergency medical condition initially presented is later identified through screening not to be an actual emergency, except in these cases:

(1) material misrepresentation, fraud, omission, or clerical error;

(2) a payment reduction due to applicable co-payments, co-insurance, or deductibles which may be the responsibility of the insured;

(3) cases in which the insured does not meet the emergency medical condition definition, unless the insured has been referred to the emergency department by the insured's primary care physician or other agent acting on behalf of the insurer.

SECTION 38-71-1540. Practice of discouraging use of 911 telephone system prohibited.

No managed care organization may engage in any practice to prohibit or discourage the appropriate use of the 911 emergency telephone system which may adversely impact the health of its enrollees.

SECTION 38-71-1550. Severability.

If any provision of this article or the application of any provision to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the article which can be given effect without the invalid provision or application, and to this end the provisions of this article are severable.

ARTICLE 17.

PATIENTS' INSURANCE AND BENEFITS PROTECTION

SECTION 38-71-1710. Short title.

This article may be cited as the "South Carolina Patients' Insurance and Benefits Protection Act".

SECTION 38-71-1720. Definitions.

As used in this article:

(1) "Closed panel health plan" means a network plan that requires an insured or a member to seek covered health care services or supplies, except in the case of emergency, exclusively from network providers.

(2) "Eligibility" means the time at which an insured or a member is entitled to enroll under the terms of the coverage offered by the network plan by virtue of:

(a) terms of employment;

(b) an annual open enrollment period; or

(c) at any other time during which the network plan's procedures or South Carolina law allows enrollment in the plan or allows renewal in the plan.

(3) "Health insurance coverage" means coverage as defined in Section 38-71-840(14).

(4) "Network plan" means a plan as defined in Section 38-71-840(24).

(5) "Network providers" means those entities and individuals who provide covered health care services or supplies to an insured or a member pursuant to a contract with a network plan to act as a participating provider.

(6) "Open panel health plan" means a plan which permits an insured or a member to seek covered health care services or supplies exclusively from an out-of-network provider.

(7) "Out-of-network providers" means those entities and individuals who provide covered health care services or supplies who are not network providers.

(8) "Point-of-service option" means a network plan that provides benefits for services or supplies provided by network providers and provides benefits for services or supplies provided by nonparticipating network providers.

(a) In-network covered health care services provided through a licensed health maintenance organization are governed by and subject to the provisions of Chapter 33 of this title.

(b) Out-of-network coverage may be underwritten by and provided through the health maintenance organization or through a licensed insurance company. The Director of Insurance may promulgate regulations as necessary or appropriate to implement the provisions of this subsection.

(c) Any benefit limitation for out-of-network covered health care services applied to an annual or lifetime benefit limitation may be offset against the benefit limitation applicable to in-network covered health care services or supplies, regardless of whether out-of-network coverage is provided through a health maintenance organization or an insurance company.

(d) The rating methods used to establish premiums for the point-of-service option must be based on actuarially sound principles.

SECTION 38-71-1730. Employers offering closed panel health plans; employee options and payments; use of provider who has discontinued participation in plan; exclusion of certain providers; services of pharmacists and advanced practice nurses; effect of this article on other plans and coverages.

(A) For purposes of health plans offered pursuant to this section:

(1) An employer who employs more than fifty eligible employees and who offers to employees major medical, hospitalization, and surgical health insurance coverage only under a closed panel health plan, also shall offer to employees at the time of their eligibility as major medical, hospitalization, and surgical health insurance coverage a point-of-service option. An employee of an employer offering only a closed panel health plan has the right to choose whether to remain in the closed panel health plan or to choose a point-of-service option.

(2) An employer may require an employee who chooses a point-of-service option to be responsible for payment of premiums, deductibles, copayments, or other payments in excess of the benefits provided by the closed panel health plan.

(3) Differences between coinsurance percentages for in-network and out-of-network covered health care services or supplies in a point-of-service option may not exceed a maximum differential of twenty percent. The coinsurance percentage for in-network and out-of-network covered health care services or supplies provided by dentists may not exceed a maximum difference of five percent.

(4) An employee, a spouse, or a dependent receiving treatment for an illness covered under a closed panel health plan may continue to receive services from a provider who elects to discontinue participation as a closed panel plan provider, subject to the terms of the contract between the provider and the health plan.

This right of continuation is limited to a period of ninety days or the anniversary date of the plan, whichever occurs first.

(5) A point-of-service option or closed panel health plan offered pursuant to this article may not discriminate against a physician, a podiatrist, an optometrist, an oral surgeon, or a chiropractor by excluding the provider from participating in the plan on the basis of the profession. A health care plan may not exclude these providers from providing health care services which they are licensed to provide and which are covered by the plan and as determined by medical necessity under utilization review guidelines. Nothing in this section interferes in any way with the medical decision of the primary health care provider to use or not use any health care professional on a case-by-case basis.

(6) A pharmacist may provide professional services under the pharmacist's scope of practice so long as the services are provided pursuant to a prescription written by a medical doctor or dentist with whom the patient has an established physician-patient relationship. Nothing in this subsection requires a managed care plan to provide reimbursement to a pharmacist. An advanced practice nurse functioning as authorized by the State Board of Nursing Regulation 91-6 may provide professional services under the advanced practice nurse's scope of practice so long as the services provided are pursuant to protocols by a medical doctor with whom the patient has an established physician-patient relationship. A point-of-service option offered pursuant to this section may not discriminate against an advanced practice nurse. Nothing in this subsection requires a managed care plan to provide reimbursement to an advanced practice nurse.

(7) Nothing contained in this article affects in any way a plan exempted by the federal Employee Retirement Income Security Act of 1974 or any South Carolina law in existence before January 1, 1999, and state employee health insurance programs or any political subdivision self-funded health insurance program; and this article does not affect the right of an employer to specify plan design or affect the right of a plan to credential or re-credential a provider. Nothing contained in this article affects accident-only, blanket accident and sickness, specified disease, credit, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability or other insurance coverage designed solely to provide payments on a per diem, fixed-indemnity, or nonexpense incurred basis, coverage for Medicare or Medicaid services pursuant to a contract with state or federal government, worker's compensation or similar insurance, or automobile medical payment insurance.

(B) This section applies only to employers who employ more than fifty eligible employees and who offer as major medical, hospitalization, and surgical health insurance coverage, only a closed panel health plan.

SECTION 38-71-1740. Responsibility for errors and omissions by parties to managed care participating provider agreements; limitations on network providers to discuss treatments, risks and legal obligations with an insured or member prohibited; permissible limitations.

(A) For purposes of any health insurance plan, health maintenance organization, or any other health benefits plan offered in this State under the jurisdiction of South Carolina law:

(1) Each party to a managed care participating provider agreement is responsible for the legal consequences and costs of his own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. A clause in a participating provider agreement to the contrary is unlawful in this State, as a matter of public policy, whether entered into before or after January 1, 1999.

(2) To the extent that a network plan requires an insured or a member to receive health benefits through a network of providers, the provisions of participating provider agreements may not limit the network provider's:

(a) ability to discuss with an insured or a member, the treatment options available to the insured or member, risks associated with treatments, utilization management decisions, and recommended course of treatment;

(b) legal obligations to an insured or a member as specified under the provider's professional license.

(B) Nothing in this section:

(1) prevents a network plan from prohibiting disclosure by network providers of trade secrets;

- (2) subjects a network plan to liability for clinical decisions made solely by the network provider; and
- (3) limits the ability of the network plan otherwise prudently to administer its provider contracts.

SECTION 38-71-1750. Disclosures required of network plans.

A network plan must disclose in writing, using the plain and ordinary meaning of words so as reasonably to ensure comprehension by the insured or member, and make available to an insured or a member at the time of enrollment:

- (1) services or benefits under the plan, including limitations on services;
- (2) rules regarding copayments, prior authorization, and review requirements that apply to the benefits plan of the insured or member;
- (3) potential financial liability for the insured or member to pay for a portion of services received from an out-of-network provider;
- (4) financial obligations of the insured or member for items and services both in and out of the network;
- (5) the number, mix, and distribution of network providers and a current list of network providers upon request from an insured or a member;
- (6) the rights and responsibilities of an insured or a member, including an explanation of any appeals process for the denial of care or services under the plan;
- (7) the existence of any limitations on the choice of providers by an insured or a member.

SECTION 38-71-1760. Promulgation of regulations.

The Director of the Department of Insurance or his designee shall promulgate regulations to implement the provisions of this chapter.

ARTICLE 19.

HEALTH CARRIER EXTERNAL REVIEW ACT

SECTION 38-71-1910. Short title.

This article may be cited as the “Health Carrier External Review Act”.

SECTION 38-71-1920. Definitions.

For purposes of this article:

- (1) “Adverse determination” means a determination by a health carrier or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided:
 - (a) does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; or
 - (b) is experimental or investigational and involves a condition that is life-threatening or seriously disabling, and the requested service or payment for the service is, therefore, denied, reduced, or terminated.
- (2) “Authorized representative” means:
 - (a) a person to whom a covered person has given express written consent to represent the covered person in an external review;
 - (b) a person authorized by law to provide substituted consent for a covered person; or
 - (c) a family member of the covered person or the covered person’s treating health care professional when the covered person is unable to provide consent.

- (3) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.
- (4) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- (5) "Covered person" means an insured, subscriber, enrollee, or other individual entitled to covered benefits under a health benefit plan.
- (6) "Director or his designee" means the Director of the South Carolina Department of Insurance or a person designated by the director.
- (7) "Facility" means an institution providing health care services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.
- (8) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee, at the completion of the health carrier's internal appeal process.
- (9) "Health benefit plan" means a policy, contract, or certificate issued by a health carrier that provides benefits consisting of medical care provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer, except:
- (a) coverage only for accident or disability income insurance or any combination of accident and disability income insurance;
 - (b) coverage issued as a supplement to liability insurance;
 - (c) liability insurance, including general liability insurance and automobile liability insurance;
 - (d) workers' compensation or similar insurance;
 - (e) automobile medical payment insurance;
 - (f) credit-only insurance;
 - (g) coverage for on-site medical clinics;
 - (h) other similar insurance coverage specified in regulations under which benefits for medical care are secondary or incidental to other insurance benefits;
 - (i) if offered separately:
 - (i) limited scope dental or vision benefits;
 - (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these;
 - (iii) other similar, limited benefits, as are specified in regulations;
 - (j) if offered as independent, noncoordinated benefits:
 - (i) coverage only for a specified disease or illness;
 - (ii) hospital indemnity or other fixed indemnity insurance;
 - (k) if offered as a separate insurance policy:
 - (i) Medicare supplemental health insurance, as defined under Section 1882(g)(1) of the Social Security Act;
 - (ii) coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code; and
 - (iii) similar supplemental coverage under a group health plan;
 - (l) any health benefit plan offered or administered by the State Budget and Control Board.
- (10) "Health care professional" means a physician, dentist, or other person properly licensed, where required, to furnish health care services.
- (11) "Health care provider" or "provider" means a health care professional or a facility.
- (12) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(13) “Health carrier” means an entity that provides health insurance coverage in this State and an insurance company, a health maintenance organization, and any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.

(14) “Independent review organization” means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(15) “Life-threatening condition or disease” means a condition or disease which, according to the current diagnosis by the covered person’s treating physician, has a high probability of causing the covered person’s death within three years.

(16) “Medical and scientific evidence” means:

(a) peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meets the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and Medlars database Health Services Technology Assessment Research;

(c) medical journals recognized by the Secretary of Health and Human Services, under Section 1861 (t)(2) of the federal Social Security Act;

(d) these standard reference compendia: the American Hospital Formulary Service--Drug Information; the American Medical Association Drug Evaluation; the American Dental Association Accepted Dental Therapeutics; and the United States Pharmacopoeia--Drug Information;

(e) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(17) “Person” means a corporation, partnership, association, voluntary organization, individual, or any other entity, organization, or aggregation of individuals.

(18) “Retrospective review” means a review of medical necessity conducted after services have been provided to a patient; this term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(19) “Serious medical condition” means a health condition or illness that requires immediate medical attention, where failure to provide immediate medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

(20) “Seriously disabling” means a health condition or illness that involves a serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

(21) “Utilization review” means a system for reviewing the necessary, appropriate, and efficient allocation of health care resources and services given or proposed to be given to a patient or a group of patients.

SECTION 38-71-1930. Application of this article.

(A) Except as provided in subsection (B), this article applies to all health carriers that provide or perform utilization review, including those plans subject to regulation under Chapter 33.

(B) This article does not apply to the administrative services performed on behalf of a self-funded plan subject to the Employee Retirement Income Security Act (ERISA) of 1974.

(C) For purposes of this article, notice to the subscriber or insured entitled to covered benefits under a health benefit plan shall constitute notice to the covered person. This subsection does not affect the health

plan's obligations under a court order requiring a parent to provide health coverage pursuant to Section 20-7-1200, et seq.

SECTION 38-71-1940. Notice of right to request a review; notice of adverse determination.

(A) A health carrier shall notify the covered person in writing of the right to request an external review and include the appropriate statements and information set forth in subsection (B) at the time the health carrier sends written notice of either an adverse determination or a final adverse determination.

(B)(1) The health carrier shall include in the notice required under subsection (A) a clear and concise description of the right of the covered person to request a standard external review pursuant to Section 38-71-1970 or an expedited external review pursuant to Section 38-71-1980 upon receipt of an adverse determination or a final adverse determination and the circumstances under which the covered person is not required to exhaust the health carrier's internal appeal process or is considered to have exhausted the health carrier's internal appeal process pursuant to Section 38-71-1960.

(2) In addition to the information to be provided pursuant to subsection (B)(1), the health carrier shall include a brief description of both the standard and expedited external review procedures.

(3) As part of any forms provided under subsection (B)(2), the health carrier shall include an authorization form, or other document promulgated or approved by the director or his designee, by which the covered person, for purposes of conducting an external review under this article, authorizes the health carrier to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

(C) A notice, statement, or form required by this section must achieve a score of no lower than 70 on the Flesch Reading East Test and must be printed in no smaller than 12 point type. No part of the notice, statement, or form may be printed in all capitals. A notice, statement, or form required by this section must include a statement of the right of the covered person to contact the director or his designee for assistance. The statement must include the telephone number and address of the director or his designee.

(D) A notice, statement, or form required by this section must be approved by the Department of Insurance. The director or his designee shall promulgate standard language, in a specified font size and type for any notice, statement, or form required by this section. Use of the standard language in the specified font size and type promulgated by the department pursuant to this section shall constitute compliance with the notice requirements of this section.

SECTION 38-71-1950. Requests for external review.

(A) All requests for external review must be made in writing to the health carrier.

(B) A covered person or his authorized representative may make a request for an external review of an adverse determination or final adverse determination only when the amount payable for covered benefits is at least five hundred dollars.

(C) A covered person is not entitled to an external review of a retrospective review determination unless the covered person has exhausted the health carrier's internal appeal process and may be held financially responsible for the covered benefits.

SECTION 38-71-1960. Exhaustion of internal appeal process.

(A)(1) Except in cases where the covered person's treating physician has certified in writing that the covered person has a serious medical condition, or where the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational and the covered person's treating physician has provided the certifications required pursuant to Section 38-71-1980, a request for a standard or expedited external review may not be made until the covered person has exhausted the health carrier's internal appeal process.

(2) A covered person is considered to have exhausted the health carrier's internal appeal process for purposes of this section, if the covered person or his authorized representative:

(a) has filed an appeal involving an adverse determination pursuant to the health carrier's internal appeal process; and

(b) the health carrier has not issued a written decision within the time frames set forth in the health carrier's internal appeals process after receipt of all information necessary to complete the appeal and the covered person or his authorized representative has not agreed to a delay.

(B) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal appeal process whenever the health carrier agrees to waive the exhaustion requirement.

(C) If the requirement to exhaust the health carrier's internal appeal process is waived under subsection (B), the covered person or his authorized representative may file a request in writing for an external review.

SECTION 38-71-1970. Requests for external review.

(A)(1) Within sixty days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an external review with the health carrier.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:

(a) the covered person has a life-threatening disease or seriously disabling condition; and

(b) at least one of the following situations is applicable:

(i) standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) standard health care services or treatments are not medically appropriate for the covered person; or

(iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and

(c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

(B)(1) Within five business days from the date the health carrier receives a request for an external review, the health carrier or its designee shall:

(a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct an external review; and

(b) send the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization; or

(c) inform the covered person or his authorized representative in writing that the request does not meet the criteria for external review pursuant to this article and include a statement explaining the reason for nonacceptance and the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee;

(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination .

(b) Immediately upon making the decision under subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) Within five business days after receipt of the request for external review from the health carrier, the independent review organization shall determine whether all the information, certifications, and forms required to process an external review, including the release form provided under Section 38-71-1940B(3) have been provided. The independent review organization shall immediately notify the covered person or his authorized representative in writing if additional information is required.

(2) The independent review organization shall include in the notice provided pursuant to subsection (C)(1) a clear statement that the covered person or his authorized representative may submit in writing to the independent review organization within seven business days following the date of receipt of the notice additional information and supporting documentation that the independent review organization shall consider when conducting the external review.

(3) If the request is not:

(a) complete, the independent review organization shall inform the covered person or his authorized representative what information or materials are needed to make the request complete; or

(b) accepted for external review, the independent review organization shall inform the covered person or his authorized representative and the health carrier in writing of the reasons for its nonacceptance.

(D)(1) If a request for external review is accepted for external review, the independent review organization shall notify the health carrier and the covered person or his authorized representative.

(2) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(3) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, at the time a request is accepted for external review pursuant to subsection (C)(3),

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (D)(3)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) Notwithstanding the provisions of subsection (D)(3)(b)(ii), the panel shall consist of the number of physicians or other health care professionals considered appropriate by the independent review organization who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide a written opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

(ii) of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care

service or treatment would not be substantially increased over those of the standard services or treatment; and

(iii) analysis of the medical and scientific evidence used in making the determination.

(E)(1) The independent review organization shall review all of the information and documents received from the health carrier and any other information submitted in writing to the independent review organization by the covered person or his authorized representative.

(2) Upon receipt of any information submitted by the covered person or his authorized representative pursuant to subsection (C)(2), the independent review organization immediately shall forward the information to the health carrier.

(F)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) within five business days of making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (F)(3), the health carrier shall send written notice to the covered person or his authorized representative and the independent review organization.

(b) the independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (F)(4)(a).

(G) In addition to the documents and information provided or transmitted pursuant to this section, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(1) the covered person's relevant medical records;

(2) the treating health care provider's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;

(4) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

(5) any applicable clinical review criteria developed and used by the health carrier or its designee; and

(6) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the Federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(H)(1) Within forty-five days after the date of receipt of the request for an external review by the health carrier, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the covered person or his authorized representative and the health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

(3) The independent review organization shall include in the notice sent pursuant to subsection (H)(1):

- (a) a general description of the reason for the request for external review;
 - (b) the date the independent review organization received the assignment from the health carrier;
 - (c) the date the external review was conducted, if appropriate;
 - (d) the date of its decision;
 - (e) the principal reason or reasons for its decision;
 - (f) the rationale for its decision;
 - (g) references to the evidence or documentation, including the practice guidelines, considered in reaching its decision; and
 - (h) the written opinions of the clinical peer review panel, if any.
- (4) Within five business days of receipt of a notice of a decision pursuant to subsection (H)(1) reversing the adverse determination or final adverse determination, the health carrier shall approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.
- (I) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination, and payment arrangement.

SECTION 38-71-1980. Expedited external review.

(A)(1) Within fifteen days after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 38-71-1940, a covered person or his authorized representative may file a request for an expedited external review with the health carrier at the time the covered person receives:

- (a) an adverse determination if the covered person's treating physician has certified that the covered person has a serious medical condition;
 - (b) a final adverse determination if:
 - (i) the covered person's treating physician has certified that the covered person has a serious medical condition; or
 - (ii) the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency medical care, as defined in Section 38-71-1520(2), but has not been discharged from a facility, if the covered person may be held financially responsible for the emergency medical care.
- (2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the request for review must include a certification from the covered person's treating physician who must be a licensed physician qualified to practice in the area of medicine appropriate to treat the covered person's condition that:
- (a) the covered person has a life-threatening disease or seriously disabling condition; and
 - (b) at least one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the covered person;
 - (ii) standard health care services or treatments are not medically appropriate for the covered person; or
 - (iii) the recommended or requested service or treatment is more beneficial than the standard health care service or treatment covered by the health carrier; and
 - (c) medical and scientific evidence using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is more beneficial to the covered person than available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatments.

(B)(1) At the time the health carrier receives a request for an expedited external review, the health carrier or its designee as expeditiously as reasonably possible shall:

- (a) assign an independent review organization from the list of approved independent review organizations compiled and maintained pursuant to Section 38-71-2000 to conduct the expedited external review; and
- (b) send all the documents and any information considered in making the adverse determination or final adverse determination to the independent review organization by overnight delivery service or any other reasonably available expeditious method; or
- (c) inform the covered person or his authorized representative that the request does not meet the criteria for external review pursuant to this article and include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.

(2) Except as provided in subsection (B)(3), failure by the health carrier or its designee to send the documents and information within the time specified in subsection (B)(1) may not delay the conduct of the external review.

(3)(a) If the health carrier or its designee fails to send the documents and information within the time specified in subsection (B)(1), the independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the decision under subsection (B)(3)(a), the independent review organization shall notify the covered person or his authorized representative and the health carrier.

(C)(1) In reaching a decision, the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process, as set forth in Chapter 70, or the health carrier's internal appeal process.

(2) If the denial of coverage is based on a determination that the health care service or treatment recommended or requested is experimental or investigational,

(a) the independent review organization shall:

(i) immediately select a clinical peer review panel pursuant to subsection (C)(2)(b) to conduct the external review; and

(ii) based on the opinions of the clinical peer reviewers on the panel, make a decision to uphold or reverse the adverse determination or final adverse determination.

(b)(i) notwithstanding the provisions of subsection (C)(2)(b)(ii), the panel shall consist of the number of physicians or other health care professionals, considered appropriate by the independent review organization, who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) The health carrier may require that the panel consist of at least three physicians or other health care professionals who meet the minimum qualifications described in Section 38-71-2010 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(iii) Neither the covered person nor his authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected for the clinical peer review panel.

(c) Each member of the clinical peer review panel shall provide an opinion to the independent review organization on whether to uphold or reverse the adverse determination or the final adverse determination. Each clinical peer reviewer's opinion shall include a description:

(i) of the covered person's medical condition, which is the subject of the adverse determination or final adverse determination;

(ii) of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more beneficial to the covered person than standard services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of the standard services or treatment; and

(iii) analysis of the medical and scientific evidence used in making the determination.

(D) In addition to the documents and information provided or transmitted pursuant to this section, the independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

- (1) the covered person's relevant medical records;
- (2) the treating health care provider's recommendation;
- (3) consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, his authorized representative, or the covered person's treating provider;
- (4) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;
- (5) any applicable clinical review criteria developed and used by the health carrier or its designee; and
- (6) if adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

(a) the recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration; or

(b) medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(E)(1) The health carrier may reconsider its adverse determination or final adverse determination at any time.

(2) Reconsideration by the health carrier may not delay or terminate the external review.

(3) The health carrier may terminate the external review only if the health carrier reverses its adverse determination or final adverse determination.

(4)(a) As expeditiously as reasonably possible upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (E)(3), the health carrier shall send notice to the covered person or his authorized representative and the independent review organization.

(b) The independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subsection (E)(4)(a).

(F)(1) As expeditiously as reasonably possible, but in no event more than three business days after the date of receipt of the request for an expedited external review by the health carrier, the independent review organization shall provide notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the:

(a) covered person or his authorized representative; and

(b) health carrier.

(2) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, the independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel, if more than one physician or other health care professional serves on the panel.

(3) If the notice provided pursuant to subsection (F)(1) was not in writing, within two days after the date of providing that notice, the independent review organization shall:

(a) provide written confirmation of the decision to the covered person or his authorized representative and the health carrier; and

(b) include the information set forth in Section 38-71-1970(H)(3).

(4) As expeditiously as reasonably possible after receipt of the notice of a decision pursuant to subsection (F)(1) reversing the adverse determination or final adverse determination, the health carrier shall approve the covered benefit that was the subject of the adverse determination or final adverse determination, subject to applicable contract exclusions, limitations, or other provisions.

(G) The assignment by a health carrier of an approved independent review organization to conduct an external review in accordance with this section must be fair and impartial. The health carrier and the independent review organization shall comply with standards promulgated by the director or his designee by regulation or bulletin to ensure fairness and impartiality in the assignment by health carriers of approved independent review organizations to conduct external reviews, including its term, its termination, and payment arrangement.

SECTION 38-71-1990. External review decisions final; exceptions.

(A) An external review decision is binding on the health carrier.

(B) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law. If such other remedies are available, the covered person or his authorized representative may not, in these proceedings, utilize, disclose, or introduce in evidence information generated during or findings reached by the independent review organization.

(C) A covered person or his authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination.

SECTION 38-71-2000. Approval of independent review organizations.

(A) The director or his designee shall approve independent review organizations eligible to be assigned to conduct external reviews to ensure that an independent review organization satisfies the minimum qualifications established under Section 38-71-2010.

(B) The director or his designee shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews and may establish an advisory committee with appropriate representation to review the applications. No member of the advisory committee may be liable to any person for any acts or omissions arising out of or related to the approval or reapproval of independent review organizations pursuant to this act.

(C)(1) An independent review organization wishing to be approved to conduct external reviews under this article shall submit the application form and include with the form all documentation and information necessary for the director or his designee to determine if the independent review organization satisfies the minimum qualifications established under Section 38-71-2010.

(2) The director or his designee may charge an application fee that independent review organizations shall submit to the director or his designee with an application for approval and reapproval.

(D)(1) Except as provided in subsection (D)(2), an approval is effective for two years.

(2) The independent review organization must notify the director or his designee of any material changes in qualifications, including removal or loss of accreditation by a nationally recognized private accrediting entity, approved by the director or his designee pursuant to subsection (E). Whenever the director or his designee determines that an independent review organization no longer satisfies the minimum requirements established under Section 38-71-2010 or has violated a provision of this article, the director or his designee shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this article that is maintained by the director or his designee pursuant to subsection (F).

(E) An independent review organization accredited by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet the minimum qualifications established pursuant to Section 38-71-2010, which accrediting entity has been approved by

the director or his designee, may be deemed to meet the minimum qualification requirements set forth in Section 38-71-2010.

(F) The director or his designee shall maintain and periodically update a list of approved independent review organizations and approved nationally recognized private accrediting entities.

(G) The director or his designee may promulgate regulations or bulletins to carry out the provisions of this section.

SECTION 38-71-2010. Standards for approval of independent review organizations.

(A) To be approved under Section 38-71-2000 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in Sections 38-71-1970 and 38-71-1980 that include, at a minimum:

(1) a quality assurance mechanism in place that ensures:

(a) that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(b) the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

(c) the confidentiality of medical and treatment records and clinical review criteria; and

(d) that any person employed by or under contract with the independent review organization adheres to the requirements of this article;

(2) a toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(3) agree to maintain and provide to the director or his designee the information set out in Section 38-71-2030.

(B) All clinical peer reviewers assigned by an independent review organization to conduct external reviews must be physicians or other appropriate health care providers who:

(1) are knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person; and

(2) hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review.

(C) In addition to the requirements set forth in subsection (A), an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

(D)(1) In addition to the requirements set forth in subsections (A), (B), and (C), to be approved pursuant to Section 38-71-2000 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent review organization to conduct the external review may have a material professional, familial, or financial conflict of interest with:

(a) the health carrier that is the subject of the external review;

(b) the covered person whose treatment is the subject of the external review or his authorized representative;

(c) any officer, director, or management employee of the health carrier that is the subject of the external review;

(d) the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) the facility at which the recommended health care service or treatment would be provided; or

(f) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

SECTION 38-71-2020. Liability of independent review organizations and personnel.

No independent review organization, or employee, officer, or director of an independent review organization or health care professional who furnishes services to an independent review organization is liable to any person for any acts or omissions arising out of or related to an external review conducted pursuant to this article, except for cases of wilful and intentional misconduct.

SECTION 38-71-2030. External review; written records; reports.

(A)(1) An independent review organization assigned pursuant to Section 38-71-1970 or Section 38-71-1980 to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the director or his designee, as required under subsection (A)(2).

(2) Each independent review organization required to maintain written records on all requests for external review pursuant to subsection (A)(1) for which it was assigned to conduct an external review shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

(3) The report shall include in the aggregate and for each health carrier:

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

(4) The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

(B)(1) Each health carrier shall maintain written records in the aggregate and for each general type of health benefit plan offered by the health carrier on all requests for external review that are filed with the health carrier during a calendar year.

(2) Each health carrier required to maintain written records on all requests for external review pursuant to subsection (B)(1) shall submit to the director or his designee, no later than March first of each year and upon request by the director or his designee, a report in the format specified by the director or his designee.

(3) The report shall include in the aggregate and by type of health benefit plan:

(a) the total number of requests for external review and the manner in which they were resolved;

(b) the average length of time for resolution;

(c) a summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director or his designee; and

(d) any other information the director or his designee may request or require.

(4) The health carrier shall retain the written records required pursuant to this subsection for at least three years.

(C) The director or his designee shall make the reports required in this section available to any person for inspection and copying upon request.

SECTION 38-71-2040. Health carrier to pay for external review.

The health carrier shall pay for the external review.

SECTION 38-71-2050. Health carrier to inform covered persons of rights related to external review.

(A) Each health carrier shall include a description of the external review procedures in either the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(B) The description required under subsection (A) shall include a statement of the right of the covered person to contact the director or his designee for assistance. The statement shall include the telephone number and address of the director or his designee.

(C) In addition to subsection (B), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

SECTION 38-71-2060. Regulations.

The director or his designee may, after notice, promulgate reasonable regulations or bulletins to carry out the provisions of this article.